

UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI  
NORTHERN DIVISION

THE UNITED STATES OF AMERICA PLAINTIFF  
VS. CIVIL NO. 3:16CV00622CWR-FKB  
THE STATE OF MISSISSIPPI DEFENDANTS

VOLUME 10

BEFORE THE HONORABLE CARLTON W. REEVES  
UNITED STATES DISTRICT JUDGE  
MORNING SESSION  
JUNE 12, 2019  
JACKSON, MISSISSIPPI

REPORTED BY: BRENDA D. WOLVERTON, RPR, CRR, FCRR  
Mississippi CSR #1139

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\*\*\* DAILY TRANSCRIPT \*\*\*

## 1 APPEARANCES:

2 FOR THE PLAINTIFF: MS. MEGAN RUSH  
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4 MR. JORGE CASTILLO  
5 MR. PATRICK HOLKINS6 FOR THE DEFENDANT: MR. JAMES W. SHELSON  
7 MR. REUBEN V. ANDERSON  
8 MR. HOWARD DAVID CLARK III  
9 MS. MARY JO WOODS10  
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1                   THE COURT: Good morning. I apologize for the delay.  
2 I was ready to come out. I got a call at 9:00 o'clock that I  
3 had to take care of.

4 Housekeeping matters. Is there anything we need to --  
5 Ms. Rush has something for me. Going to be spot on today.  
6 Right? I'm just -- we try to --

7 MS. RUSH: Your Honor, I did want to give you a road  
8 map of the day.

9 THE COURT: Okay.

10 MS. RUSH: We are -- our first witness will be Sheriff  
11 Travis Patten, followed by Dr. Judith Baldwin, one of our  
12 experts in our clinical review. And if we have time, we will  
13 get started on Katherine Burson, another expert from our  
14 clinical review.

15 THE COURT: Okay. Thank you.

16 Well, let me -- when we scheduled this matter, and I  
17 know the parties have been working to -- you know, to sort of  
18 maybe in response to some of the things that the court has been  
19 saying, I do not want either party to feel like you are not --  
20 I don't want you to abdicate your responsibility of putting on  
21 the case that you wanted to put on. In no way am I suggesting  
22 or trying to interfere with you changing or truncating your  
23 case in such a way that you do not make your record in the way  
24 that you wanted to make it. I mean, I cajole you and sort of  
25 suggest to you and all of that, but I do not want the parties

1 to feel like the judge is somehow interfering with our ability  
2 to put on the case that we wanted to put on. I'm not doing  
3 that.

4 MS. RUSH: We appreciate that, Your Honor. And we  
5 appreciate all of your suggestions. But we feel like we have  
6 just been able to move a little bit faster than we anticipated.  
7 But we appreciate it. Thank you.

8 THE COURT: Okay. All right. For other logistical  
9 housekeeping things, I know on the front end, one of the --  
10 maybe that was at the pretrial conference we were talking about  
11 post trial briefing, the possibility, the request for the  
12 government -- I have two governments here. I don't need to  
13 ignore my own state government. But the United States had a --  
14 sort of laid the predicate that it might ask for a number of  
15 weeks to do post trial briefing.

16 And as we -- as you think about your case, I will let  
17 you know that I do not intend to give a whole lot of time to do  
18 the post trial briefing. So as you think about how your case  
19 is progressing and on how you are doing it, I think -- I think  
20 the suggestion was maybe a minimum or a maximum of 60 days or  
21 something like that, I believe, as I recall. I am highly  
22 inclined not to do that amount of time. I think the issues are  
23 front and center. I think -- I don't know if I will need all  
24 of that time to digest what I'm hearing and what is going on,  
25 so as you're thinking about how your case is evolving, and this

1 is for everyone, I do not think I will -- I don't want to  
2 delay. That's my thing. I don't want to unnecessarily delay a  
3 final ruling on this for very long. So, you know, if I do 60  
4 days, that means, you know, that could possibly mean, you know,  
5 way into the fall, and I just don't want to do that.

6 Ms. Rush.

7 MS. RUSH: Thank you, Your Honor. It would be helpful  
8 for us to have a sense, if the court has a preference already,  
9 of what kind of post trial findings and filings that the court  
10 would prefer. We would expect a post trial findings in fact  
11 and conclusions of law and potentially a post trial brief,  
12 but -- if the court would find that helpful. But that would  
13 help us plan --

14 THE COURT: Right. That's --

15 MS. RUSH: -- for timing if you have a sense -- sorry.

16 THE COURT: I'm sorry. I mean, that's what I would  
17 want, post trial findings of fact, conclusions of law. And  
18 that's all. But I guess what I was alluding to, I did not --  
19 I'm likely -- instead of a 60-day turnaround to do it, it may  
20 be like 14 days or something like that. I mean, it may be a  
21 quick turnaround as far as the parties submitting anything  
22 because of what I need to do and how soon I need to get it done  
23 based on my other obligations in the late summer and fall and  
24 winter and staffing and all of that. So that's what I'm  
25 concerned about. So it would be, you know, findings of fact,

1 conclusions of law.

2 The one advantage everyone has here, unlike in most  
3 cases, is that we are getting daily transcripts now already, so  
4 the record will be done on the day that the trial ends already.  
5 You won't have to wait around for a record. So it will be  
6 proposed findings of fact, conclusions of law, and I do -- you  
7 know, I know the parties would want to have sufficient time. I  
8 just do not believe that that time will exceed more than two  
9 weeks. I don't know yet, but I don't think it would exceed --  
10 only because of how it might impact on what I need to get done.  
11 That's all.

12 MS. RUSH: We will be ready. Thank you, Your Honor.

13 THE COURT: All right. Okay. The government has all  
14 the resources in the world. They can get it done. And I say  
15 that to both governments.

16 Is there anything else we need to take up before we  
17 call our next witness?

18 MR. SHELSON: Your Honor, just in response to that,  
19 the State's position is that conclusions of law and findings of  
20 fact make sense, and that, separate from that, a brief, a post  
21 trial brief would not be necessary. That's our position.  
22 We're fine with whatever time the court has in mind and we  
23 think that reasonable page limits would also be in order.

24 THE COURT: Oh, yeah, it will be.

25 MR. SHELSON: Thank you, Your Honor.

THE COURT: All right. Yes. And my view of reasonable may just line up with the parties' view of reasonable as well. Thank you, Mr. Shelson.

Is the United States ready to call its next witness?

MR. CASTILLO: Yes, Your Honor.

THE COURT: You may proceed.

MR. CASTILLO: Good morning, Your Honor.

THE COURT: Good morning.

MR. CASTILLO: Jorge Castillo for the United States.

The United States calls Sheriff Travis Patten as its next witness.

THE COURT: All right.

TRAVIS PATTEN,

having first been duly sworn, testified as follows:

THE COURT: Get comfortable, Sheriff Patten. You're in the hot seat now. It looks like that seat is wobbling in some way. But if you're fine, that's good.

Just speak directly into the microphone. Try to speak at a pace at which the court reporter can keep up with you. Allow the attorneys to finish their question or statement before you begin to speak so that the two of you will not be speaking at the same time and just make sure all your responses are verbal, please.

So for the record, could you please state and spell your name?

1                   THE WITNESS: My name is Travis Patten, T-R-A-V-I-S,  
2 P-, as in Paul, A-T-T-E-N.

3                   THE COURT: Thank you.

4                   You may proceed.

5                   And you are doing great. That's -- the volume and  
6 everything is great.

7                   Go ahead.

8                   DIRECT EXAMINATION

9                   BY MR. CASTILLO:

10                  Q    Good morning, Sheriff.

11                  A    Good morning.

12                  Q    As I'm sure you know, I'm going to ask you several  
13 questions today. For the purpose of this trial, the relevant  
14 fact period goes up through December 31st, 2018. I'm going to  
15 ask that your answers focus on that time period. Okay?

16                  A    Yes.

17                  Q    Sheriff, what is your current job?

18                  A    Sheriff of Adams County, Mississippi.

19                  Q    How long have you been the Adams County sheriff?

20                  A    Since January 4, 2016.

21                  Q    What part of the state is Adams County in?

22                  A    Southwest Mississippi.

23                  Q    And broadly speaking, what are the responsibilities of the  
24 sheriff of Adams County?

25                  A    Criminal patrol, criminal investigation. We serve civil

1 process. We seize property, sell property. We're over the  
2 courthouse. We're over the jail. And we do a lot of civil  
3 commitments as well.

4 Q You mentioned you run a jail. Where is that jail located?

5 A It's 306 State Street.

6 Q Where is that in relation to your main sheriff's office?

7 A It's in the same building.

8 THE COURT: And that's in Natchez? You mentioned  
9 Adams County. I don't think you --

10 THE WITNESS: Yes. The city of Natchez, Adams County.  
11 It is in the city limits of Natchez.

12 THE COURT: Okay. Thank you.

13 BY MR. CASTILLO:

14 Q Do you hold people in your jail who haven't been charged  
15 with a crime?

16 A Yes, we do.

17 Q And why are they there?

18 A Civil commitments.

19 Q Does a mobile crisis team serve Adams County?

20 A There is a mobile crisis team that's supposed to serve  
21 Adams County, but we don't ever see them.

22 Q Is there a crisis stabilization unit or a CSU in Adams  
23 County?

24 A No.

25 Q Who do the people of Adams County call in a mental health

1 crisis?

2 A The Adams County sheriff's office.

3 Q Is that a problem?

4 A It is.

5 Q Have you voiced your concerns about this problem with  
6 anybody in the State?

7 A Yes, I have.

8 Q With whom?

9 A Brent Hurley.

10 Q Have you spoken with other sheriffs about this issue?

11 A Yes, I have.

12 Q Have you told any other sheriffs that you are testifying in  
13 this case?

14 A I just told the president of the Sheriffs Association  
15 yesterday that I was testifying in this case, and he was glad  
16 that I was because he said we all need this help.

17 Q Let's talk about the civil commitment process for persons  
18 with mental illness in Adams County for a minute. What's the  
19 sheriff's office role in a civil commitment process?

20 A Basically what we do is we pick them up after a commitment  
21 has been issued. We make sure that we get them to the hearing  
22 on time. Once the hearing is done, if they are committed, we  
23 transport them to wherever the court has deemed that they need  
24 to go. If it's outpatient, you know, we release them. But in  
25 the meantime, if that hearing is a day or two off, we actually

1 hold them in the jail until we can get them there.

2 Q And for the people you transport to an inpatient facility,  
3 who picks them up?

4 A We do.

5 Q Do you hold people in jail while they're going through this  
6 process?

7 A Yes, we do.

8 Q Where do you hold them?

9 A We have two holding cells that we retrofitted with a thick  
10 padding that we hold them in in our jail.

11 Q You said they are retrofitted. What were these cells  
12 designed for?

13 A They were designed as more of your drunk tanks and for  
14 people who were combative, people who were coming off of drugs,  
15 things of that nature, but they were not originally designed to  
16 be mental health -- for mental health patients.

17 Q Could you describe these holding cells for us?

18 A They are about a 7-by-8, approximately 7-by-8 cell. They  
19 don't have beds in them or anything like that. The only thing  
20 they have is a toilet and a sink and thick padding all over.

21 Q I would like to show you some pictures.

22 MR. CASTILLO: Your Honor, may I approach?

23 THE COURT: Yes, you may.

24 BY MR. CASTILLO:

25 Q (Tenders documents.) Sheriff Patten, I just handed you

1 three documents, Plaintiff's Demonstrative Exhibits 13, 14 and  
2 15. Are these pictures of the commitment cells?

3 A Yes, they are.

4 MR. CASTILLO: Your Honor, we present these for  
5 identification purposes.

6 THE COURT: All right.

7 (EXHIBITS PDX-13, PDX-14 AND PDX-15 MARKED FOR  
8 IDENTIFICATION)

9 BY MR. CASTILLO:

10 Q Looking at these pictures, I don't see a bed. Where do  
11 people sleep when they're in the commitment cell?

12 A We give them a mattress and they sleep on the floor.

13 Q If you look at Number 13, Plaintiff's Demonstrative  
14 Exhibit 13 and 14, there is something on the floor. What is  
15 that?

16 A If you look at the center, picture 13 here, you'll see that  
17 hole is -- that's an actual drain. And if you look around the  
18 edges of that drain, you can see -- you can kind of see how  
19 thick the padding is that we had to put in there. If you look  
20 to the right of that where it's kind of awkwardly shaped, that  
21 happened when one of our mental health consumers were chewing  
22 on the padding.

23 Q How many people can be held in these commitment cells?

24 A One.

25 Q And how many do you have?

1 A Two.

2 Q Have you ever needed to hold more than two people who are  
3 suffering a mental health crisis?

4 A Absolutely.

5 Q Where do they go?

6 A What we have to do then is we take them upstairs and we  
7 have to clear out a regular cell. And we put them in there and  
8 we have to put a 24-hour, seven-day-a-week watch on them, guard  
9 on them watching that cell. Because these cells here  
10 (indicating) are equipped with cameras inside the cells. The  
11 ones upstairs are not.

12 Q How often do you need to use an overflow space to hold  
13 people in mental health crises?

14 A It's quite often. Because, again, these cells are not just  
15 for the mentally ill.

16 Q I would like to show you some more pictures.

17 MR. CASTILLO: Your Honor, may I approach?

18 THE COURT: Yes, you may.

19 BY MR. CASTILLO:

20 Q (Tenders documents.) Sheriff Patten?

21 A Yes.

22 Q What are the pictures that I just handed you?

23 A These are two of the cells upstairs in our jail that we  
24 clear out when we have an overflow in those two holding cells.

25 MR. CASTILLO: Your Honor, these images are

1 Plaintiff's Demonstrative Exhibits 16 and 17 which we offer for  
2 identification purposes.

3 THE COURT: Okay. Any objection from the State? I  
4 did not ask that with respect to the 13, 14, 15. Was there any  
5 objection as to PDX-13, 14, 15?

6 MR. CLARK: No objection, Your Honor.

7 THE COURT: Okay. And 16, 17?

8 MR. CLARK: None.

9 THE COURT: Okay. Thank you. They will be marked for  
10 identification.

11 (EXHIBITS PDX-16 AND PDX-17 MARKED FOR IDENTIFICATION)

12 BY MR. CASTILLO:

13 Q Do these overflow cells have any padding?

14 A No.

15 Q Were they designed for holding people in mental health  
16 crisis?

17 A No.

18 Q Do the persons that you pick up for a commitment hearing  
19 wait in jails for that hearing?

20 A Yes, they do.

21 Q And do they wait in jail after a hearing before they are  
22 admitted to a treatment facility?

23 A If there is not a bed readily available, yes, we hold them  
24 until we can get them transported.

25 Q And how long does that process from picking them up to

1 getting them to a treatment facility take?

2 A It can take anywhere from 24 to 48 hours to a week and a  
3 half. Minimum 24 to 48, max about a week and a half sometimes,  
4 depending on bed availability.

5 Q Are these people receiving any mental health treatment  
6 during their time in the jail?

7 A No.

8 Q Is there a local community mental health center that's near  
9 the jail?

10 A It is.

11 Q What organization?

12 A Southwest Mental Health.

13 Q And where are they located?

14 A Directly across the street, about 10 to 12 feet across the  
15 street from the sheriff's office in Natchez, Mississippi.

16 Q When you transport people to a commitment hearing and to  
17 inpatient facility treatment, what vehicles do you use?

18 A We have a transport van that is equipped with cameras.

19 Q Are you always able to use that transport van?

20 A No, because sometimes we have more than one committal that  
21 needs to be transported. So if that van is on a trip to  
22 Meridian, I have to pull somebody off the street and put them  
23 in a patrol car and send them to wherever they need to go.

24 Q You said sometimes. How often?

25 A It's quite often. Because you've got to look -- if we're

1 taking a trip to Meridian or the Coast, and that van is gone,  
2 it's not going to be back within eight hours. So it happens  
3 more than we need it to happen.

4 Q Are the persons you're transporting handcuffed?

5 A Yes, they are.

6 Q Based on your observations, what is your impression of what  
7 it's like in the jail for the people who are being civilly  
8 committed?

9 A You know, when you look into those people's eyes who are  
10 being civilly committed, when you look into the eyes for a  
11 normal man to hear the clink of that cell close, it does  
12 something to your psyche. So for the ones who have a  
13 heightened sense of fear, it is pure terror.

14 Q How do you feel about this?

15 A I feel like they don't need to be in my jail or anybody's  
16 jail.

17 Q I want to focus now on your office work with people who  
18 have serious mental illness outside of the civil commitment  
19 process. Do you have staff who have been assigned to work with  
20 people on these cases?

21 A Yes, we have a team that is trained in CIT. CIT team.

22 Q What does CIT stand for?

23 A Crisis intervention team.

24 Q And how many officers do you have trained in CIT?

25 A Three.

1 Q What sort of training do they go through?

2 A They went through the 40-hour CIT training course. They  
3 have been to training for the -- dealing with the mentally ill,  
4 first aid training. They went to the training, the trainer  
5 course for citizens with special needs. They've also been  
6 through human behavior and conflict management training.

7 Q Do these --

8 A Deescalation as well. I'm sorry. Deescalation as well.

9 Q How many do you have, again?

10 A Three.

11 Q And do these three officers work strictly with persons  
12 having mental health crises?

13 A No, they do not.

14 Q Who else do they work with?

15 A They work with victims of crimes.

16 Q What triggers a response from the officers trained in CIT  
17 to a scene where there is someone having a mental health  
18 crisis?

19 A Basically it could be a call from the parents or loved ones  
20 who already know that that person is mentally ill because we  
21 have dealt with them before, or it could be our supervisors on  
22 the street who recognize the signs that this is not somebody  
23 who needs to go to jail, this is somebody who is having a  
24 mental health crisis and we need CIT team called out.

25 Q Are your CIT-trained officers mental health clinicians?

1 A No, they're not.

2 Q Can your CIT-trained officers call clinicians when their  
3 training is not sufficient to diffuse a mental health crisis?

4 A We tried that before. It didn't work too well. No.

5 Q Will Region 11's mobile crisis team come provide  
6 stabilization services?

7 A I haven't seen them since I have been there.

8 Q Where is Region 11's mobile crisis --

9 A McComb, Mississippi.

10 Q Which county is that?

11 A Pike County.

12 Q And how far is that from Adams County?

13 A It is about an hour away.

14 Q What is your understanding about why they don't respond to  
15 your county?

16 A To me, my understanding would be that they are already  
17 overwhelmed with the cases they're dealing with over there. We  
18 tried in 2016 and 2017, but it's just not feasible for to think  
19 that if they've got a crisis in Madison or somewhere else, that  
20 they're going to be able to respond to Adams County to a crisis  
21 that's happening now. And when you have officers on scene who  
22 have to respond within 15 minutes, it's like an eternity when  
23 you're dealing with somebody that's out of control. So it just  
24 doesn't work. They have actually called us and asked us to go  
25 deal with situations.

1 Q What do you mean by that, someone calls mobile crisis?

2 A Yes. Some people have called mobile crisis, and mobile  
3 crisis, because they know I have CIT-trained officers, have  
4 asked them to go and deal with it. And we have, because that's  
5 the people we serve.

6 Q You have a binder in front of you. I would like to -- you  
7 to turn in your binder to Plaintiff's Exhibit PX-415 which has  
8 been previously admitted into evidence. This map shows the  
9 rate of mobile crisis response per capita by CMHC region. The  
10 dark red areas have high rates of mobile crisis utilization and  
11 the light red or pinkish areas are where there is low rates of  
12 mobile crisis utilization. Do you see Adams County on this  
13 map?

14 A Yes, I do.

15 Q Does it appear that Region 11 has a high or a low ratio of  
16 crisis responses relative to other regions?

17 A We have an extremely low.

18 Q Is this consistent with your experience?

19 A Yes.

20 Q Back to your binder. If you can turn to joint Exhibit 52.  
21 And using the numbers on the bottom right of the document, turn  
22 to page 5. This has been previously admitted into evidence.  
23 This is the Department of Mental Health's annual report for  
24 fiscal year 2015. In this page it discusses mobile crisis  
25 response teams. I want to focus your attention on the first

1 paragraph. I'm just going to read it:

2 "Mobile crisis response teams provide community-based  
3 crisis services that deliver solution-focused and  
4 recovery-oriented behavioral health assessments and  
5 stabilization of crisis in the location where the individual is  
6 experiencing the crisis. Mobile crisis response teams work  
7 hand in hand with the local law enforcement, chancery judges  
8 and clerks and the crisis stabilization units to ensure a  
9 seamless process."

10 Would you describe your experience with mobile crisis as  
11 working hand in hand?

12 A No.

13 Q Is mobile crisis -- is there a mobile crisis team providing  
14 assessments and stabilization services in the location where  
15 the individual is experiencing the crisis in Adams County like  
16 it's described here?

17 A No.

18 Q As sheriff of Adams County, would you like a mobile crisis  
19 response team to provide crisis services with or instead of the  
20 sheriff's office?

21 A Absolutely.

22 Q Staying with this document, if you can turn to page 13,  
23 again using the numbers on the bottom right. I'm sorry. Page  
24 14, using the numbers on the bottom right, where it says crisis  
25 intervention teams. Do you see that?

1 A Yes.

2 Q Would you please read the -- will you please begin reading?  
3 And I will tell you to stop when it's time.

4 A "Crisis intervention teams are partnerships between local  
5 law enforcement agencies and a variety of agencies, including  
6 community mental health service centers, primary health  
7 providers, advocacy groups such as NAMI, and behavioral health  
8 professionals. Officers joining a team learn the skills they  
9 need to respond to people experiencing a mental health crisis  
10 and divert them to an appropriate setting for treatment,  
11 ensuring people are not arrested, taken to jail due to symptoms  
12 of their illness."

13 Q Thank you. Do your CIT-trained officers have a partnership  
14 with the local community mental health center and other  
15 behavioral health professionals when it comes to responding to  
16 people in mental health crises?

17 A No.

18 Q Are you a mental health clinician?

19 A No.

20 Q Is there a place where your CIT-trained officers can divert  
21 people who are experiencing crisis so they don't have to go to  
22 jail?

23 A No.

24 Q Again sticking with joint Exhibit 52 and turning to page 22  
25 using the numbers on the bottom right, do you see this map?

1 A Yes.

2 Q This map shows the CSUs that existed in Mississippi as of  
3 July 2018. Is there a CSU anywhere in Region 11?

4 A No.

5 Q In 2018, did a CSU open in Adams County?

6 A No.

7 Q Would you like a CSU to open in Adams County?

8 A Absolutely.

9 Q Why is that?

10 A Because it's tasking for us when we have to take somebody  
11 as far as we do and actually have to go through the process of  
12 getting them committed, when some of them may not need to be  
13 committed. Some of them may be able to get stabilized right  
14 here at home. So --

15 Q CSUs provide crisis services. In Adams County, do you  
16 believe that there is a need for services that could prevent  
17 mental health crises from happening in the first place?

18 A Yes, I do.

19 Q I want to get into the numbers for a minute. On average,  
20 how many people go through the civil commitment process in  
21 Adams County?

22 A On average, we have an average of about -- I would say  
23 about eight a month committals.

24 Q Could you please turn to page 21 of the DMH annual report  
25 for fiscal year 2018? This is a breakdown of the adult

1      psychiatric admissions by county to the state hospitals during  
2      that time. Do you see Adams County?

3      A      Yes.

4      Q      Where does Adams County appear to fall in civil commitments  
5      to Mississippi State Hospital?

6      A      They appear to fall behind Hinds County and Rankin County  
7      to the Mississippi State Hospital.

8      Q      So third behind Hinds and Rankin?

9      A      Yes.

10     Q      How does Adams County population stack up against Hinds and  
11     Rankin County?

12     A      We are probably a fifth of the size of Hinds and Rankin  
13     County population-wise.

14     Q      Of the people who are committed to the state hospitals, are  
15     you seeing any people being repeatedly committed?

16     A      Yes.

17     Q      And for those people with repeat admissions, what are you  
18     seeing after they go to the state hospital?

19     A      You know, when we go pick them back up and they have been  
20     stabilized, what we are seeing is they are thinking they are  
21     okay permanently and they're not taking their medication or  
22     they don't have the insurance that they need to stay on their  
23     medication, and they don't have the support they need to keep  
24     encouraging them to stay on it. So we see them begin to  
25     self-medicate, but some of them even try to work the system.

1       So that's what we're seeing quite often.

2       Q    And what happens that you are seeing them again in a  
3       commitment process?

4       A    Basically what happens again is the family or their loved  
5       ones are at their wit's end. They are calling me again because  
6       they can't control their loved ones. Even though they love  
7       them, they can't control them. So commitments are being issued  
8       again and we're back picking them up and going through the  
9       hearing process and sending them right back up there.

10      Q    If there was in Adams County someone to receive these  
11       people cycling and offer them help with mental illness  
12       symptoms, --

13                   THE COURT REPORTER: I'm sorry.

14                   MR. CASTILLO: Yes, ma'am. I'm sorry. I went too  
15       fast there.

16       BY MR. CASTILLO:

17      Q    If there was someone in Adams County to receive these  
18       people who are cycling and offer them help with mental illness  
19       symptoms, do you think that would make a difference?

20      A    I think if they could keep their hands on some of them, I  
21       think it absolutely would make a difference.

22                   MR. CASTILLO: If I can just have one second to  
23       confer?

24                   THE COURT: Okay.

25                   (SHORT PAUSE)

1 BY MR. CASTILLO:

2 Q I just have maybe one or two questions left. Since you  
3 became sheriff in January of 2016, have you seen any  
4 improvements in the civil commitment rates or process in Adams  
5 County?

6 A No.

7 MR. CASTILLO: No further questions.

8 THE COURT: All right. Thank you.

9 Any cross-examination of this witness?

10 MR. ANDERSON: Could you give us just two minutes,  
11 Your Honor?

12 THE COURT: Yes. Uh-huh.

13 (SHORT PAUSE)

14 **CROSS-EXAMINATION**

15 BY MR. CLARK:

16 Q Good morning, Sheriff Patten.

17 A Good morning.

18 Q You testified about services you would like in Adams County  
19 to see offered, and I want to clarify that. What services  
20 would you like to see offered?

21 A I would love to see a mobile crisis stabilization unit  
22 there. I would love to see a partnership going on between  
23 possibly the State and some of our local medical clinicians  
24 there. And I would love to have a crisis team that actually  
25 responds, a mobile crisis team that actually responds.

1 Q Sure. Anything else?

2 A You know, if we could have a CSU, that would be great for  
3 us. We need a crisis stabilization unit. We have people  
4 trained to divert people to that but we need the team to make  
5 sure they get there and the unit to put them in. Right now,  
6 Adams County doesn't have that.

7 Q And there was some testimony about the CIT, the crisis  
8 intervention team. You would agree with me that CIT is a good  
9 program. Correct?

10 A I think it is a great program but I think it is a program  
11 that cannot stand alone.

12 Q That cannot what? Stand alone?

13 A It cannot stand alone.

14 Q Sure. And you would agree with me that persons with mental  
15 health issues need treatment. Correct?

16 A Absolutely.

17 Q And your position is in receiving that treatment, I believe  
18 your words were, "They don't need to be in my jail," meaning  
19 they don't need to receive that treatment in your jail?

20 A Exactly.

21 Q Okay. You would agree with me that some of those persons  
22 need to be treated in a state hospital. Is that correct?

23 A The more violent ones, absolutely. And the reason I say  
24 that is because when we take them to some of the private  
25 facilities, if they get violent, they go on a list where they

1 can't come back. So there is a need, yes.

2 Q There is a need to be institutionalized in a state  
3 hospital?

4 A Yes. Not all, but the violent ones.

5 Q Would you agree with me that there must be a collaborative  
6 effort between the local centers and the state institutions?

7 A I think you need that. Certain people require certain  
8 things and I think it definitely needs to be a collaborative  
9 effort. Because that's what's happening. You have resources  
10 here, you have resources there, but nobody is the glue between  
11 them. And I think what some of the -- if partnerships are  
12 formed, CSU unit put in place, and people are actually doing  
13 the jobs that they are supposed to be doing, I think it could  
14 work.

15 Q You think it will work?

16 A I think it could if you had a collaborative effort going,  
17 yes.

18 MR. CLARK: Thank you. Nothing further. Well, one  
19 second, Your Honor.

20 THE COURT: All right.

21 (SHORT PAUSE)

22 BY MR. CLARK:

23 Q Sheriff Patten, you testified a moment ago about violent  
24 individuals need to receive treatment in state institutions.  
25 Could you give us an example of a violent individual that you

1 have dealt with that was committed to a state hospital or that  
2 needed to be?

3 A Yes. We had one guy who beat his little brother with an  
4 aluminum baseball bat. He beat him pretty bad, and we couldn't  
5 get any private institutions to deal with that guy because, you  
6 know, he was pretty violent, so he needed to go to the State.

7 Q And did he?

8 A He went after about a year in jail. He did.

9 Q He went to the State Hospital?

10 A He did. It took us about a year to get him there.

11 Q And which state hospital was that?

12 A Mississippi State Hospital.

13 Q Okay.

14 MR. CLARK: Nothing further.

15 THE COURT: All right. For my own information, could  
16 you tell me your name?

17 MR. CLARK: I'm sorry. Trey Clark.

18 THE COURT: Okay. Thank you, Mr. Clark.

19 Any redirect of this witness?

20 MR. CASTILLO: No, Your Honor.

21 THE COURT: I have a couple questions for you, Sheriff  
22 Patten, and the parties will be permitted to follow up based on  
23 what I have asked.

24 In giving an example, your last example, you said  
25 there was a young man who stayed in your jail for a year?

1                   THE WITNESS: He did, Judge. He was one of the  
2 pretrial, and they wanted to see whether he could -- they  
3 wanted to see was he mentally stable to stand trial. And we  
4 fought and we fought and we fought to try to get that man help,  
5 but it took us almost a year to get him to the State Hospital.  
6 Yes, sir.

7                   THE COURT: Well, did he ever go to trial or did they  
8 find that he was not competent to go to trial?

9                   THE WITNESS: He is still at the State Hospital.

10                  THE COURT: He is still at the State Hospital now?

11                  THE WITNESS: Yes, sir.

12                  THE COURT: But are you telling me he stayed in Adams  
13 County jail for a year?

14                  THE WITNESS: We have it documented where he stayed  
15 there that long. And we have it documented where we, you know,  
16 made several calls to our local judges and officials telling  
17 them he doesn't need to be here, he needs to go get help.

18                  THE COURT: During that period of time that he was in  
19 Adams County, was he in one of these -- do you remember what  
20 cell he was in?

21                  THE WITNESS: He was in the holding cell for the  
22 longest. And then what we had to do was I actually had to hire  
23 somebody. I had to go before the board of supervisors and hire  
24 an extra body because we had to put him up top in an area where  
25 he could be maintained where we could utilize those holding

1       cells again. I had to hire another worker, rearrange  
2       schedules, everything.

3               THE COURT: You indicated, I think it was PDX-13, 14  
4       and 15, these cells that are not equipped with beds. I think  
5       you said that y'all put some sort of pallet or something for  
6       those persons who have to stay there for more than several  
7       hours or for more than a day or so.

8               THE WITNESS: Yes.

9               THE COURT: During this time that he was housed at the  
10       facility, did he utilize those rooms for more than a day or  
11       two?

12               THE WITNESS: He did. He utilized them for as long as  
13       we could. And that's why we had to keep changing our schedule,  
14       because we would put him there as long as we could hold him,  
15       but when other people came in who needed them, we had to take  
16       him back upstairs and put manpower right there to watch him the  
17       whole time. So we got as much --

18               THE COURT REPORTER: I'm sorry.

19               THE WITNESS: I'm sorry. Where do you want me to  
20       start?

21               THE COURT REPORTER: But when other people came in, --

22               THE WITNESS: But when other people came in, we would  
23       move him back up top. We would have to come in. We would have  
24       to schedule staff to watch him. The only time he wasn't in  
25       these cells were when we didn't have other people who needed

1       those services. Otherwise, we would move him back up top and  
2       have a guard there with him the whole time. And it was tasking  
3       on us. That's what pushed us to keep calling the judges asking  
4       them, calling the DA, "Can y'all please do something with this,  
5       because he doesn't need to be here?"

6               THE COURT: Okay. You are in your first term as  
7       sheriff.

8               THE WITNESS: Yes, sir, I am.

9               THE COURT: Okay. Prior to serving as sheriff, were  
10       you a deputy sheriff or anything like that?

11               THE WITNESS: Yes, I was.

12               THE COURT: Okay. Well, I'm going to ask you about  
13       your time as being sheriff first.

14               THE WITNESS: Yes, sir.

15               THE COURT: Are you aware of others -- well, let me  
16       ask the question this way: Nobody else has stayed over there  
17       while you were as sheriff for a year?

18               THE WITNESS: Not on the mental health side, no.

19               THE COURT: All right. Has anybody else stayed over  
20       there more than six months while you were sheriff, on the  
21       mental health side?

22               THE WITNESS: Yes, but it was tied in with the  
23       criminal actions that he committed as well, and that was  
24       another one that we fought to get out of there. He actually --  
25       a guy came to his house, knocked on the door, and he shot the

1       guy through the door. But we knew this guy was one of those  
2 repeat mental health consumers, and we knew that there is no  
3 way he was going to be able to stand trial but we still had to  
4 go through the process because he shot somebody through the  
5 door. And so that was another one. He stayed about six  
6 months. And I'm going to be honest with you, Judge, we had to  
7 just recog him out. We had to recog him out.

8                   THE COURT: When you say -- tell me what recog is for  
9 the record.

10                  THE WITNESS: Release him because he was indigent. He  
11 couldn't make bond. So we recogged him out. The victim didn't  
12 want to file charges on him because he knew the guy was mental,  
13 and so we were able to get the charges dropped and we were able  
14 to push the system to make them get him some mental health.  
15 His own family wouldn't come to get him out because they were  
16 afraid of him. Even when they dropped the bond extremely low,  
17 the family just left him there to us.

18                  THE COURT: Now, how long -- prior to being sheriff,  
19 how long were you employed by the sheriff's department?

20                  THE WITNESS: By the sheriff's office in Adams County,  
21 I was employed eight years prior to becoming sheriff there.

22                  THE COURT: And what position or positions did you  
23 hold during that eight-year period?

24                  THE WITNESS: I did criminal deputy. I was in the K9  
25 unit. And I was a narcotics investigator as well.

5 THE WITNESS: As a deputy, I can't say that they were  
6 housed waiting on mental health services, Judge. But what I  
7 can say is this: I can say, as a deputy, I have seen several  
8 people who should have went through getting mental health get  
9 charged with crimes just to get them off the street. And they  
10 have sat there because their families wouldn't come get them.

11 THE COURT: Okay. Thank you.

12 Any follow-up based on what I have asked? I turn to  
13 the United States first.

14 MR. CASTILLO: No follow-up from the United States.

17 MR. CLARK: Briefly, Your Honor.

18 THE COURT: Yes, sir.

19 BY MR. CLARK:

20 Q Sheriff Patten, the individual that you were speaking about  
21 a minute ago that was there for you said roughly a year before  
22 going to the State Hospital, it's my understanding from your  
23 earlier testimony that he was arrested. Correct?

24 A He was.

25 Q He did not come to you through a civil commitment?

1 A No, he did not.

2 Q Okay. And from your testimony with Judge Reeves, I take it  
3 you understand the difference between them coming to you versus  
4 civil commitment and then as an arrestee?

5 A Yes, sir, absolutely.

6 Q Okay. Do you know or are you aware that the competency  
7 evaluation for forensic patients --

8 THE COURT REPORTER: I'm sorry.

9 THE COURT: Slow down just a little bit, Mr. Clark.

10 BY MR. CLARK:

11 Q Are you aware that the competency evaluation for forensic  
12 patients is presently under 30 days?

13 A Yes, I am.

14 Q Okay. And that the Mississippi State Hospital can't see  
15 forensic patients until the records and the orders are  
16 provided? Are you aware of that?

17 A I am. That's why we -- that's why we pushed letting them  
18 know, "You need to get him out of here."

19 MR. CLARK: Nothing further.

20 THE COURT: All right. Is this witness finally  
21 excused?

22 MR. CASTILLO: Yes, Your Honor.

23 THE COURT: All right. Mr. Patten, thank you for your  
24 testimony. You may return to your normal duties.

25 THE WITNESS: Thank you, Judge.

1 THE COURT: All right.

2 MS. RUSH: May I approach, Your Honor?

3 THE COURT: You may.

4 (SHORT PAUSE)

5 MS. VAN EREM: May I proceed, Your Honor?

9 MS. VAN EREM: Sure. The United States calls Judith  
10 Baldwin.

11 JUDITH BALDWIN,

12 having first been duly sworn, testified as follows:

13 THE COURT: Ms. Baldwin, were you in the courtroom  
14 when I gave out the last instructions to the prior witness?

15 THE WITNESS: Yes. I just came in for a little bit.

16 THE COURT: Okay. Please make sure the lawyers finish  
17 their questions before you begin to speak so that the two of  
18 you will not be speaking at the same time. Speak at a pace at  
19 which the court reporter can keep up with you. And make sure  
20 all your responses are verbal.

21                   If you will, for the record, could you state and spell  
22 your name?

23 THE WITNESS: My name is Judith Baldwin. It's  
24 J-U-D-I-T-H, B-A-L-D-W-I-N.

25 THE COURT: Thank you.

1                   You may proceed.

2                   MS. VAN EREM: Thank you, Your Honor. And my name is  
3                   Haley Van Erem for the United States.

4                   DIRECT EXAMINATION

5                   BY MS. VAN EREM:

6                   Q    Good morning, Dr. Baldwin.

7                   A    Good morning.

8                   Q    Dr. Baldwin, what is your occupation?

9                   A    I am a psychiatric mental health clinical nurse specialist.

10                  Q    Were you retained by the United States in this case?

11                  A    I was.

12                  Q    Did you conduct a clinical review of individuals who have  
13                  experienced state hospital admissions in Mississippi?

14                  A    I did.

15                  Q    Before we get into the details of your review, I would like  
16                  to ask you a few --

17                  THE COURT: Slow down just a bit.

18                  MS. VAN EREM: I'm sorry, Your Honor.

19                  THE COURT: That's all right. Follow me.

20                  MS. VAN EREM: I will try. I'm sorry.

21                  THE COURT: That's all right.

22                  BY MS. VAN EREM:

23                  Q    Dr. Baldwin, before we get into the details of your review,  
24                  I would like to ask you a few questions about your background  
25                  and experience. Can you please describe your educational

1 background?

2 A I have a four-year degree in nursing. I am a registered  
3 nurse.

4 THE WITNESS: Do I have this situated right? Can you  
5 hear me?

6 THE COURT: We hear you fine. Thank you.

7 A I have a master's degree in nursing. I have the clinical  
8 nurse specialist board certification in psychiatric nursing  
9 which is analogous to a nurse practitioner in the medical  
10 field. And I also have a Ph.D. in law, policy, and society.

11 BY MS. VAN EREM:

12 Q Have you worked as a nurse?

13 A I have.

14 Q How long have you worked as a nurse?

15 A Approximately 47 years.

16 Q What is the role of a psychiatric clinical nurse  
17 specialist?

18 A The role of a psychiatric clinical nurse specialist is also  
19 called an advanced practice role, so a nurse who can function  
20 in an expanded role, meaning he or she can diagnose, can treat,  
21 can supervise other nurses, contributes, in a way, making  
22 healthcare changes more on a global level.

23 Q Do you have experience working with people with mental  
24 illness?

25 A I do.

1 Q How long have you been working with people with mental  
2 illness?

3 A I would say for 47 years. It's my entire career.

4 Q For the individuals with mental illness that you have  
5 worked with over the years, what is the range of severity of  
6 their illnesses?

7 A I have worked with people who have temporary conditions,  
8 conditions that are adjustment disorders, maybe a grief  
9 reaction or an anxiety or a depression, and I have also worked  
10 with people who have very serious and persistent mental  
11 illness.

12 Q Has the majority of your work been spent with people with  
13 serious and persistent mental illness?

14 A It has.

15 Q Have you worked in both hospital and community-based  
16 settings?

17 A I have.

18 Q Can you just describe generally your experience working in  
19 each of those settings?

20 A Early on in my career I worked in a community psychiatric  
21 hospital. It was a small locked ward, primarily short-term  
22 stays for people. And later on in my career, starting in about  
23 the seventies, I worked more with people who were coming out of  
24 a state hospital.

25 Q Can you tell us a little bit more about that role working

1 with people coming out of the state hospital?

2 A I was hired by the Department of Mental Health in  
3 Massachusetts, and I was part of a small team. I was the nurse  
4 on that team, and the team was tasked with bringing people out  
5 of the state hospital, about 300 people, and integrating them  
6 into the community. And thereby the team was also tasked with  
7 developing community-based services to support those people.

8 THE COURT REPORTER: I'm sorry.

9 A Tasked with developing services that would support those  
10 people in the community.

11 BY MS. VAN EREM:

12 Q What year did you begin working in that role?

13 A In 1978.

14 Q What were the circumstance in which those teams were  
15 formed?

16 A At that time the Commonwealth of Massachusetts was in the  
17 process of deinstitutionalization. They had statewide funding  
18 to do this. The goal was to close many of the state hospitals  
19 in the state and to integrate the majority of people in those  
20 state hospitals into the community.

21 Q What was your role on that team?

22 A My role was -- the title was community nurse advisor,  
23 aftercare services coordinator. What the role was to -- I  
24 coordinated comprehensive clinical services in the community  
25 for people coming out of the hospital and integrating into the

1       community. So it was to be part of this team to develop  
2       services and also to see patients directly.

3       Q    And did you work with the state hospital in that role?

4       A    Yes. That was a big part of the role, was to interface  
5       with the state hospital to meet with staff there on a regular  
6       basis to talk about plans about how we would help people come  
7       out. So it was a very big piece of the work.

8       Q    And as part of this role, did you develop community-based  
9       services?

10      A    I did.

11      Q    And we'll talk a little bit more later about some of the  
12       community-based services that you worked on developing. But  
13       after your role as community nurse advisor, did you have any  
14       other roles in developing community-based services in  
15       Massachusetts?

16                   THE COURT REPORTER: I'm sorry.

17      BY MS. VAN EREM:

18      Q    After your role as community nurse advisor, did you have  
19       any other roles in developing community-based services in  
20       Massachusetts?

21      A    I did.

22      Q    What were those roles?

23      A    I was director of outpatient services for a period of time  
24       and then I became director of outpatient services. As the  
25       agency grew and more and more people became patients in the

1       community-based setting, the role expanded. And then  
2       ultimately I was the vice president for quality management  
3       within that agency.

4       Q    What were your responsibilities as director of adult  
5       services and outpatient services?

6       A    That was to coordinate services that had been developed for  
7       the people to make sure that they were operating at their most  
8       effective level, to supervise staff, to meet with patients and  
9       their families, and to also interface with the hospital staff  
10      at various levels.

11      Q    You testified that you developed and supervised  
12      community-based services in Massachusetts. At a high level,  
13      can you describe the community-based services that were  
14      developed?

15      A    Yes. It was the continuum of care within the community.  
16      So to start with, 24-hour crisis. And we had developed that  
17      from the beginning, so I was actually one of three prescreeners  
18      on that team just to get a sense of how the operation was  
19      going. So we had the 24-hour crisis.

20           We also had an outpatient medication clinic which was  
21      dispensing, monitoring, prescribing. We developed housing  
22      within the community, a variety of housing. We also had a case  
23      management function where people would visit people in their  
24      homes or people would come into the office for meetings and so  
25      to stay really in touch with the folks that we had brought out.

1       We interfaced with various community agencies and had contracts  
2       with those agencies to work with them, agencies that interface  
3       with patients. And we had day programs and supported  
4       employment.

5       Q      What was the time frame in which these services were  
6       developed?

7       A      We started in 1978, and in 1980 we received a federal  
8       community mental health center grant, so it grew then in leaps  
9       and bounds. And I would say over the next five years that we  
10      had developed those services.

11      Q      When did you leave your work in the Massachusetts mental  
12      health system?

13      A      That was in 2009.

14      Q      Where did you work after that work with the Massachusetts  
15      mental health system?

16      A      I worked at the Veterans Administration in Boston, the V.A.  
17      Medical Center.

18      Q      When did you work for the Veterans Administration?

19      A      I started there in 2009 and I stayed until 2015.

20      Q      What was your role?

21      A      I was the nurse manager for the Home-Based Primary Care  
22      Program.

23      Q      What is the Home-Based Primary Care Program?

24      A      Home-Based Primary Care Program is a -- it's a national  
25      model that the V.A. has developed, and it is geared completely

1       towards serving veterans in their homes. And so it is a  
2       multidisciplinary team with nurses and case managers and social  
3       workers and doctors. And everything was completed in the  
4       patient's home through patient visits. And the goal was to  
5       keep people out of the hospital to avoid nursing home placement  
6       or at least to have short hospital stays.

7       Q     As part of your work experience, have you conducted  
8       clinical assessments of individuals with mental illness?

9       A     I have.

10      Q     Why do you conduct assessments in your work?

11      A     In nursing, but I believe in all healthcare professions,  
12       the assessment is that it is the foundation of the work that  
13       you are going to be doing with the patient so it's very  
14       important to do that initial assessment with the individual for  
15       a variety of reasons.

16      Q     What sources of information did you use in completing those  
17       assessments in your prior work history?

18      A     Well, it's a fairly standard outline, but first you would  
19       ask the person why they are coming, then what is it that's  
20       troubling them or what their presenting problem is, but then  
21       also to talk with them about their history, their mental  
22       history or their medical history, their family history, their  
23       social history, any kinds of contributing factors that might  
24       play into what kind of treatment might be best for this person  
25       and their problem, and to also ask them what they want, what

1       would work for them, their goals.

2                   MS. VAN EREM: Your Honor, I move to have Dr. Judith  
3       Baldwin qualified as an expert in psychiatric nursing, serious  
4       mental illness, and assessments for community-based mental  
5       health services.

6                   THE COURT: Any objection?

7                   MR. SHELSON: No, Your Honor.

8                   THE COURT: Dr. Baldwin will be admitted as an expert  
9       on the designated -- in the designated areas.

10                  You may proceed.

11                  MS. VAN EREM: Thank you, Your Honor.

12                  BY MS. VAN EREM:

13                  Q     Dr. Baldwin, I would like to talk now about the review you  
14       conducted in Mississippi. How many individuals were in your  
15       review?

16                  A     Thirty.

17                  Q     What sources of information did you use in making your  
18       determinations in your review?

19                  A     What sources of information did I use?

20                  Q     Yes.

21                  A     I interviewed the individual. Whenever available, I also  
22       interviewed collateral contacts, which could include family  
23       members or friends or other people that would have some  
24       informal relationship with them. I reviewed medical records  
25       from the State Hospital and from the CMHCs.

1 Q Where did you conduct the interviews?

2 A That was in a variety of places. We met with people in  
3 their own homes, we met with people in their family's homes,  
4 personal care homes, group homes, nursing homes. I also went  
5 to two state hospitals, two correctional facilities, and I also  
6 met with one individual at the college in -- on Capitol Street  
7 in Jackson, Jackson State College.

8 Q What records did you review?

9 A I reviewed all records that were provided to me. That was  
10 State Hospital records, community mental health center records.  
11 And within those, sometimes there were discharge summaries or  
12 other summaries from the community hospitals as well.

13 Q Did you submit a final report?

14 A I did.

15 Q If you will turn in your binder to tab 403. Is PX-403 your  
16 report?

17 A It is.

18 Q After your report was finalized, did you have an addendum?

19 A I did.

20 Q What did your addendum consist of?

21 A I had the occasion -- we had tried to interview family  
22 members and other collaterals, as I said, when they were  
23 available. And a response came back to my outreach on that  
24 after I had submitted my final report, and it was the brother  
25 of one of the folks in my sample. And so I did interview him,

1 but my report had gone in. So what I did was document that  
2 interview and I submitted it as an addendum.

3 Q Is your addendum in front of you labeled PX-399?

4 A Yes, it is.

5 Q Dr. Baldwin, did you also submit an errata to your report?

6 A I did.

7 Q Are the corrections you made in your errata contained in  
8 the document called Errata to Expert Report of Dr. Judith  
9 Baldwin dated May 24th, 2019 and labeled PX-403A?

10 A It is.

11 Q How would you describe those corrections?

12 A The first bullet is there was a mistake in calculation. I  
13 had answered the question about is an individual at serious  
14 risk for institution in a State Hospital, and I said 19 and it  
15 should have been 18. I had miscounted or miswritten it in the  
16 report. I actually rendered an opinion on three of those  
17 people.

18 The other errata is I had a typo that I found upon later  
19 review where I had put the date as '17, 2017, when, in fact, it  
20 was 2015.

21 MS. VAN EREM: Your Honor, PX-403, Dr. Baldwin's  
22 report, has been preadmitted but I move to admit PX-399 and  
23 403A into evidence.

24 THE COURT: PX --

25 MS. VAN EREM: 399 and 403A, which are her addendum

1 and errata.

2 THE COURT: Any objection from the State?

3 MR. SHELSON: No, Your Honor.

4 THE COURT: All right. PX-399 and 403A will be  
5 received into evidence.

6 (EXHIBITS PX-399 AND PX-403A MARKED)

7 BY MS. VAN EREM:

8 Q Dr. Baldwin, does your report with the addendum and errata  
9 you identified accurately reflect your opinions and conclusions  
10 in this case?

11 A It does.

12 Q What standards did you rely on in reaching your  
13 conclusions?

14 A I relied on my professional experience, also my -- of what  
15 I have seen work over my career, what has been successful for  
16 people similar to the people in the sample. I also relied on  
17 my knowledge of evidence-based practices and what has been  
18 proven to work for individuals living in the community with  
19 serious mental illness.

20 I also relied on reviews of the literature both that I had  
21 access to and was familiar with, but also that was provided to  
22 me by Dr. Robert Drake who was the lead on the team, outlining  
23 again evidence-based practices for success in the community.

24 Q Let's briefly go over what you were determining in your  
25 conclusions and then we will go back and talk about your

1 conclusions more. First, what were you trying to determine for  
2 the 30 individuals you reviewed?

3 A I was trying to determine if, one, if they would oppose  
4 receiving community-based services or living in the community  
5 if community-based services were -- or reasonable services were  
6 available to them. I was trying to determine if they had spent  
7 too much time in a state hospital or could have avoided some of  
8 the admissions or all of the admissions that they had  
9 experienced.

10 I was also looking at would they be appropriate for  
11 community-based services and would they benefit from them. And  
12 finally, if they were at risk for rehospitalization.

13 Q Do you have a demonstrative slide showing your findings  
14 regarding these questions?

15 A I believe I do.

16 MS. VAN EREM: Your Honor, may I approach?

17 THE COURT: Yes, you may.

18 BY MS. VAN EREM:

19 Q (Tenders document.) This has been marked for  
20 identification as PDX-18. Does this slide fairly and  
21 accurately depict your findings?

22 A It does.

23 Q Starting with the first finding on this slide, for the 30  
24 people you reviewed, how many did you find could have avoided  
25 or spent less time in the State Hospital with reasonable

1                   community-based services?

2       A    I found that all of them could have avoided or spent less  
3                   time in the hospital.

4       Q    How did you go about answering the question of whether the  
5                   person would have avoided or spent less time in the State  
6                   Hospital?

7       A    It was a combination of things. I looked at the record,  
8                   the records that were provided to me and what the circumstances  
9                   were around the admissions. Also, I looked at the pattern of  
10                  admissions, if the same kinds of things were happening each  
11                  time in between. I looked at the community-based services that  
12                  were or were not being provided either before and/or in between  
13                  hospital admissions.

14                  I also spoke with the individuals and oftentimes with  
15                  family members or others who were familiar with their  
16                  experience and asked did they think they could have avoided  
17                  going in the hospital had something been available to them and,  
18                  if something was available, what was it, and asked them to  
19                  identify it. And often, they did.

20       Q    Generally, why did you find that all 30 individuals in your  
21                  review could have avoided or spent less time in a State  
22                  Hospital?

23       A    These individuals are very similar to people that I have  
24                  worked with in my career, and I am aware of what works for  
25                  people living with serious mental illness, as these individuals

1 are, and am aware that if they had had access to those  
2 services, then they could have avoided or at least have had a  
3 much shorter stay in an acute care setting.

4 Q Going to the second question, how many individuals did you  
5 find were at serious risk of institutionalization?

6 A And I found that it was 18, and that is 86 percent of the  
7 people that were out of the hospital at that time.

8 Q And so that's out of the 21 people who were in the  
9 community at the time for whom you formed an opinion. Is that  
10 right?

11 A Correct.

12 Q How did you reach the conclusion that these individuals  
13 were at serious risk?

14 A I was looking at the patterns of their hospitalizations and  
15 looking at the -- what community services were or were not  
16 available to them, and noticing that the same situation was  
17 happening over and over again, and that there was limited  
18 community-based services that were either in place when they  
19 left the hospital the last time or if they had not been in the  
20 hospital, they weren't in place so that really the individuals  
21 were at risk because nothing -- there wasn't much that was  
22 supporting them in the community in between.

23 Q What can happen when a person with serious mental illness  
24 is not getting the services they need to support them?

25 A Serious mental illness is a chronic disease. People can

1 live successfully in the community. They can recover, but they  
2 also will have exacerbations of symptoms on occasion. And in  
3 particular, if they are not receiving supports or they're not  
4 taking medication or they're not working with a service to help  
5 them stay stable in the community, and their symptoms will  
6 increase periodically and they -- if they are left untreated,  
7 they will exacerbate to the point where they may need a higher  
8 level of care.

9 Q Can you provide an example of someone who you determined  
10 was at serious risk of hospitalization at the time you reviewed  
11 them? And you can reference PX-400 in your binder, which is a  
12 list of names of individuals involved in the review, along with  
13 their numbers, which we will be using the numbers to preserve  
14 confidentiality.

15 A And so to be clear, you would ask me about someone who is  
16 at serious risk?

17 Q That's right.

18 A Okay. I would like to talk about person 107.

19 Q Can you please briefly describe the circumstances of person  
20 107? And it starts on page 136 of your report.

21 A Person 107 is a 69-year-old woman. She lives in a  
22 retirement community. She has worked her whole life. She,  
23 when well, lives very independently. She is a college-educated  
24 woman, has had a very successful career. She has two  
25 daughters. And she is diagnosed with bipolar illness.

1 Q How many times has person 107 been in a State Hospital?

2 A She has been in the State Hospital four times.

3 Q What led to those State Hospital admissions?

4 A This is -- her situation is fairly typical of someone who  
5 is diagnosed with bipolar illness. In the case of person 107,  
6 she might become feeling very well and decide that she doesn't  
7 want to take a dose of her medication or she might feel  
8 suspicious about her medication and over time gradually take  
9 less and less of her prescribed medication. And then, as her  
10 daughter described, and as described in the record, she  
11 escalates into a full manic state, which is characteristic of  
12 bipolar.

13 Q What do you mean when you say manic state?

14 A When people have bipolar I, which is what person 107 has,  
15 it's characterized by extreme mood swings, both mania where  
16 people are not sleeping, they have extreme euphoria, they are  
17 oftentimes agitated, they may have some strong suspicions but,  
18 in a sense, the world is all great and they don't need any  
19 medication, they don't need any help, they are not sleeping,  
20 they are not using good judgment.

21 It also has the reverse where people can be very, very  
22 seriously depressed.

23 Q Why did you ultimately conclude that person 107 was at  
24 serious risk of further State Hospital admissions?

25 A In speaking with her daughter, as well as herself, the

1 daughter, both she and her sister believed this is the only  
2 path to get -- commitment is the only path to get their mother  
3 stabilized and back on her medication, that they acknowledge  
4 that they cannot do this by themselves, that they try and she  
5 will not listen to them because she thinks everything is fine.

6 Q Are there community-based services that could reduce person  
7 107's risk of State Hospital admission?

8 A Do you mean do they exist?

9 Q Yes. Generally, would there be community-based services  
10 that could reduce her risk?

11 A Absolutely.

12 Q What types of services would reduce her risk?

13 A In the case of person 107, the important thing for her is,  
14 one, to have a 24-hour crisis line and, if not for her, for her  
15 daughters who might become concerned about her and could talk  
16 with a crisis clinician early on. Also to have, in her case, a  
17 case manager who has a trusting relationship with her, sees her  
18 on a regular basis on outreach and proactively and so can head  
19 off these symptoms early on before they become so exacerbated  
20 that she needs a higher level of care for her own safety.

21 Q Did person 107 have access to these services?

22 A No, I don't believe so. Could I add?

23 Q Sure.

24 A The other aspect is medication. Obviously, this is an  
25 illness that is effectively managed by medication, so that

1       would be the other service that I would see as important for  
2       her.

3       Q     What is it about person 107's illness that makes you  
4       confident that the services you mentioned could reduce her risk  
5       of hospitalization?

6       A     Because bipolar illness is one serious mental illness that  
7       has been proven time and time again to be very effectively  
8       managed by medication. It's also very predictable in that  
9       people will have these cycles as I have described them. So --  
10      and I have seen it work time and time again with very high  
11      functioning bipolar people who respond very well to their  
12      medication.

13      Q     Let's go back to your overall findings. How many  
14      individuals in your review did you find opposed receiving  
15      services in the community?

16      A     There were none who opposed.

17      Q     How did you determine whether an individual opposed  
18      community-based services?

19      A     I looked at multiple sources of information. Whenever  
20      possible, I would ask the individual themselves. Or in the  
21      course of the interview, the individual would tell me, without  
22      being asked, that they wanted to live in the community, they  
23      knew what they would need in the community to stay there and to  
24      live at their highest level of independence. I spoke with  
25      family members, again, what they thought the person would need,

1 and they had a very good idea of what that would be.

2 And then I looked in the records and documentation of  
3 people asking to leave the hospital or even identifying where  
4 they wanted to live or what services they would need.

5 Q Can you briefly give an example of an individual who told  
6 you that they preferred to live in the community?

7 A An example of someone who would prefer to live in the  
8 community? Is that what you said?

9 Q Yeah, just a brief example.

10 A Yes. And do you want the number?

11 Q Sure. You can give me the number if you would like.

12 A I'm looking at one, person 91. And throughout his  
13 interview talking about how he wanted to leave the nursing home  
14 where he was and what he would need in the community to live  
15 there. And it was so important to him and it was also  
16 documented continuously in his medical records.

17 Q Go ahead.

18 A I was going to give another example as well.

19 Q Sure.

20 A And let me see her -- this is person 109. And this is a  
21 young lady that I interviewed in the State Hospital who I found  
22 out after the fact has been discharged to a small group home.  
23 But she was very engaging, very animated, and talked about how  
24 she just wanted to make it in the community. And in going back  
25 into the hospital, she blamed herself every time. And, "I'm

1 not going to screw up this time. I'm going to get out there.  
2 I want to go in a group home and then I want to get my own  
3 place." And, you know, it was just very important to her.

4 Q Regarding the final question, how many individuals did you  
5 find were appropriate for community-based services?

6 A I found that all the individuals in my sample were  
7 appropriate.

8 Q Was that surprising to you?

9 A No.

10 Q Why not?

11 A Because I have seen it throughout my career that people can  
12 live successfully in the community at a very high level of  
13 independence who are also living with serious mental illness.  
14 The community-based services are evidence-based. I have seen  
15 them work time and time again. A different maybe combination  
16 for an individual from one to another, but they do consistently  
17 work.

18 Q Of the individuals you reviewed, how many were in the State  
19 Hospital at the time you reviewed them?

20 A I believe it was eight.

21 Q Of those eight, can you explain generally why you  
22 determined they were appropriate for community-based services?

23 A Because these are people not unlike the other people,  
24 individuals in my sample who have a variety of serious mental  
25 illness. They -- in each case, I identified strengths that

1       they had, which was different from one person to another, some  
2       the same. But I have seen in the past that individuals like  
3       this with similar symptoms, similar strengths and similar  
4       challenges, can live successfully in the community.

5       Q      Did you also determine the types of services that  
6       individuals needed to remain in the community?

7       A      I did.

8       Q      How did you make that determination?

9       A      There are a series of -- there is a continuum of care of  
10      community-based services for people with serious mental  
11      illness. They are evidence-based. And if you would like, I  
12      can list them, but there is --

13      Q      Sure. If you can briefly list them?

14      A      To start with, the crisis services, 24-hour crisis, and  
15      there is a continuum within the crisis which I won't go into,  
16      but to start with, the 24-hour hot line and to have obviously a  
17      mobile outreach capacity but also to have a crisis  
18      stabilization on the other side of crisis. To have proactive  
19      outreach through case management function. To also have access  
20      to a psychiatric prescriber. To have, when it's needed, a  
21      connection being made to primary care because often people with  
22      serious mental illness have co-morbid medical conditions. To  
23      also have supported housing, stable housing, and supported  
24      employment as needed. And finally, for people to have  
25      connection to specialty services that they might need such as

1 connection to trauma, because there are more people with  
2 serious mental illness who have had trauma histories as well.

3 Q You mentioned case management. Can that be part of PACT  
4 services?

5 A Yes. And PACT is also an evidence-based practice with  
6 those services all within one team. And case management is a  
7 very big part of that.

8 Q Can case management also be provided separately from a PACT  
9 team?

10 A It can.

11 Q Are there any recommendations for services that you made --  
12 sorry. Let me rephrase that.

13 Are there any examples of individuals where you have made  
14 recommendations beyond those core services necessary to avoid  
15 hospitalization that you just mentioned?

16 A I did.

17 Q Is person 110 an example?

18 A Person 110 is who I was thinking of.

19 Q Okay. And for person 110, did you say that he could  
20 benefit from a program geared to supporting individuals with  
21 dementia which included sensory stimuli such as recliners and  
22 hand and neck massages?

23 A I did. And person 110 is one of the three people that I  
24 said was not at risk for hospitalization. This is a -- a  
25 relatively young man who is in the end stages or advanced

1        stages of dementia. When I interviewed him, he was on a  
2        dementia unit in a nursing home. And what I did at that time  
3        was make the recommendations that I know are clinically  
4        appropriate for someone with that diagnosis.

5        Q        So are those services geared -- you know, the program  
6        geared toward supporting individuals with dementia, are those  
7        services necessary to prevent his hospitalization in a State  
8        Hospital?

9        A        Not necessarily, no.

10      Q        Why did you make the recommendation?

11      A        It was my experience, my most recent experience in the  
12     V.A., because our average age of our consumer was 85, and  
13     oftentimes there was a diagnosis of dementia, and those are  
14     evidence-based practices for people with dementia. So the  
15     nurse in me, the clinician, made the recommendations I thought  
16     were right for that man.

17      Q        And I apologize if you already mentioned this, but is  
18     person 110 at risk of admission to a State Hospital according  
19     to your review?

20      A        No, he is not.

21      Q        Now that we have talked about your overarching findings, I  
22     would like to ask about some more details. Did you make any  
23     findings in your review regarding how often some individuals  
24     are admitted to the State Hospitals?

25      A        I did. Individuals -- I have at least one gentleman I can

1 think of who just went into the State Hospital one time, and  
2 then I also have individuals on my -- in my sample who were  
3 admitted 17 times.

4 Q Why would it occur that people would have many readmissions  
5 to the State Hospital?

6 A Just so I understand, why would it occur if they would have  
7 -- why would they have many?

8 Q Let me rephrase. Why did you find that people in your  
9 review had many readmissions to the State Hospital?

10 A Often it was a dearth of community-based services in  
11 between those admissions or even before the first that was not  
12 supporting that individual in the community adequately, and so  
13 their symptoms would exacerbate, as I described before, and  
14 then they would perhaps require a higher level of care for  
15 safety.

16 Q You mentioned that some people had fewer State Hospital  
17 admissions than others?

18 A I did.

19 Q Why did some people have fewer admissions?

20 A Well, the one gentleman that I'm thinking of who had the  
21 one admission, he is a young man. He was in his thirties, and  
22 I believe that he would be at risk for rehospitalization. It  
23 would just be a matter of time. But he was young.

24 There is also the factor of supports. If people have a  
25 number of supports in the community and formal supports, then

1       that often can delay or prevent hospitalization because those  
2       supports are taking care of the individuals.

3       Q     Dr. Baldwin, did you get a sense for what people's  
4       experiences were in state hospitals?

5       A     I did. People would often tell me unsolicited, but I would  
6       also ask that. I would ask, you know, what was good about  
7       being in the state hospital, what did you not like in the state  
8       hospital, what recommendations would you make. And they would  
9       answer in that way as well.

10      Q     And what did you learn from asking those questions?

11      A     I learned that there were a number of people. There was  
12     one woman who told me it was the most humiliating experience  
13     she had ever had in her life. There was at least a couple of  
14     people who said it was like a prison, that they had been picked  
15     up by the police and that they had been taken against their  
16     will.

17           Often people talked about not having choice. More than one  
18     person described lining up to get medication. People talked  
19     about not having privacy, not having access to their things.  
20     One lady said, "I like to brush my teeth more than once a day  
21     and when I go back, my toothbrush is gone, it is put away."

22      Q     Can those experiences that you just described occur even  
23     with short admissions?

24      A     They can, yes.

25      Q     Can you provide an example from your review of someone who

1 has been admitted multiple times to State Hospitals?

2 A I can. Let me find the number for you.

3 Q Sure.

4 A This is person 98.

5 Q And can you describe person 98? It's page 89 of your  
6 report.

7 A Person 98 is a 53-year-old man. You said 89. Right?

8 Q Page 89, yes, 88 or 89.

9 A Got it. It's a 53-year-old man. He currently lives in a  
10 personal care home. He is college-educated. He has had an  
11 employment history in the past. He is diagnosed with  
12 schizoaffective disorder, bipolar type. And I saw him -- I  
13 interviewed him at the community mental health center.

14 Q How many times has person 98 been in the State Hospital?

15 A He has been in the State Hospital 14 times, according to  
16 the records.

17 Q What were the reasons that person 98 had been admitted to  
18 the State Hospital 14 times?

19 A Now, his appears to be a cyclical process as well. These  
20 admissions, he said the 14 admissions which have taken place  
21 over the past 28 years, so starting when he was a young man,  
22 and about every two years. But what happens with him is his  
23 symptoms start to increase very insidiously, and it may be  
24 because he may skip a dose of medication or he may decide he is  
25 not going to take his medication. And then he gradually

1       escalates into a threatening stance. He gets agitated. He  
2       gets angry. And the personal care home manager becomes  
3       concerned, and the other residents become fearful. And so a  
4       commitment process is initiated with him, which is what  
5       happened this last time.

6       Q     In your opinion, could some of person 98's hospital  
7       admissions have been avoided or shortened?

8       A     Absolutely.

9       Q     How did you make that determination?

10      A     Because he has a cyclical nature to his decompensations,  
11       meaning that his symptoms increase in kind of a predictable  
12       way. And so to have a case manager who is engaged with him  
13       right from the start in a trusting relationship to kind of head  
14       off symptoms or get a sense of them right from the beginning to  
15       then thereby avoid them escalating into an acute situation.  
16       Also to have 24-hour crisis service, and that would be not only  
17       available to the individual but also to the personal care  
18       manager to call ahead and say, "I think, you know, person 98,  
19       just I'm a little concerned, he is not sleeping, he is, you  
20       know, he is getting a little angry or losing his patience."

21      Q     Did person 98 have access to those community-based services  
22       before his State Hospital admissions?

23      A     Not that I'm aware of, no.

24      Q     Did you recommend that person 98 would be appropriate for a  
25       PACT team?

1 A I did.

2 Q What is it about PACT services that gives you confidence  
3 that person 98 could avoid repeated hospitalizations?

4 A PACT has a team approach and within that team is the access  
5 to the 24-hour crisis services and mobile outreach within that.  
6 Also, a crisis stabilization, which I think would be very  
7 appropriate for him. Also, the case management function. And  
8 again, the proactive outreach case management function.

9 He is someone who takes medication. He is not opposed to  
10 it. So that piece, connection to the medication through the  
11 PACT team as well.

12 And he is an individual who would like to be doing  
13 something during the day, either a day program or some kind of  
14 work. And the PACT team could support him in that regard, in  
15 addition to possibly stepping down from a personal care home  
16 into a more independent level. The PACT team could help him  
17 with that as well.

18 Q Is person 98 at serious risk of hospitalization in a State  
19 Hospital?

20 A Yes, he is.

21 MS. VAN EREM: Your Honor, it is my understanding  
22 there has not been a morning break. If you would like, we can  
23 take a break now. It's a natural stopping place. Or I can  
24 keep going.

25 THE COURT: Oh, it is a natural stopping place?

1 MS. VAN EREM: Yes.

2 THE COURT: All right. For you?

3 MS. VAN EREM: Yes.

4 THE COURT: Okay. All right. We will take our  
5 15-minute break then.

6 MS. VAN EREM: Thank you, Your Honor.

7 THE COURT: Doctor, you may step down.

8 THE WITNESS: I can sit right here?

9 THE COURT: If you wish -- if you want to stay there?

10 THE WITNESS: No. I think I would like to use the  
11 restroom.

12 THE COURT: Okay. Yeah. You can step down. By all  
13 means.

14 We are in recess. We are in recess.

15 (RECESS)

16 THE COURT: Is there anything we need to take up?

17 MS. VAN EREM: Not from the United States.

18 THE COURT: All right. Are you ready?

19 THE WITNESS: I am.

20 THE COURT: All right. You may proceed.

21 MS. VAN EREM: Thank you, Your Honor.

22 BY MS. VAN EREM:

23 Q Dr. Baldwin, I would like to continue talking about your  
24 findings, specifically that people could have avoided or spent  
25 less time in State Hospitals. Did you find that a lack of

1 access to community-based services led to unnecessary  
2 hospitalizations?

3 A I did.

4 Q And did you find that a lack of access to community-based  
5 services led to hospitalizations that were longer than  
6 necessary?

7 A I did.

8 Q What was the length of stay in State Hospitals for the  
9 individuals that you reviewed?

10 A There was a range. Some individuals stayed as short a time  
11 as a week. I have one individual within my sample who had a  
12 singular hospitalization that was 17 years, another woman 13 or  
13 14 years.

14 Q You say 17 years?

15 A Yes. Years.

16 Q Are there any examples you can think of of the individuals  
17 you reviewed who could have avoided or spent less time in State  
18 Hospitals?

19 A I can give a couple of examples if you want. The first one  
20 is person 90.

21 Q Can you please tell us a little bit more about person 90?  
22 It's on page 21 of your report.

23 A Person 90 is a 64-year-old African-American woman. She is  
24 the mother of two daughters. And when I interviewed her, she  
25 was in a personal care home. She is diagnosed with

1       schizophrenia. She does have some co-morbid medical  
2       conditions. Prior to her most recent hospitalization, she had  
3       been out of the hospital for five years and had been living in  
4       her own apartment.

5       Q     What led to her most recent hospitalization?

6       A     Person 90 takes psychotropic medication. She apparently  
7       had missed a medication appointment. And then she had missed  
8       several medication appointments over a five-month period. And  
9       during that time -- a four- to five-month period. And during  
10      that time, she also was not paying her rent. She somehow  
11      thought she was paying her rent but she was not.

12      Q     Who initiated her commitment?

13      A     That was her daughter.

14      Q     I apologize if I missed this, but you had said she had  
15      missed some medication appointments. Is that right?

16      A     She had. She had missed approximately five months worth of  
17      medication appointments, which was about five appointments.

18      Q     What actions were taken when person 90 started missing  
19      appointments?

20      A     I could find very little actions in the record. There was  
21      one notation of an outreach, but I don't believe the case  
22      manager reached person 90. And then I could not find any other  
23      follow-up.

24      Q     Based on your experience, what should have happened when  
25      person 90 started missing appointments?

1       A    This is an individual where I believe a case manager or  
2 proactive case management function should be very much involved  
3 with. And she was someone who came to her appointments. And  
4 so for her to miss an appointment would have warranted a  
5 follow-up. In the case of person 90, ideally, the case manager  
6 should be seeing her regularly on a very regular proactive  
7 basis. But in missing an appointment, the case manager would  
8 follow up, make a call. If she did not -- he or she did not  
9 reach person 90, to go make a home visit, figure out what's  
10 going on, talk with the daughter, talk with the landlord and  
11 try to, again, head off symptoms before they exacerbate into  
12 a -- in this case, it was five months.

13       Q    Had person 90's services been more intensive, could they  
14 have prevented her State Hospital admission?

15       A    I believe so, yes.

16       Q    Regarding her hospital admission, based on your review, why  
17 did person 90's daughter initiate commitment?

18       A    What was in the record is that person 90 had not been  
19 paying her rent and she had been evicted. She was subject to  
20 being evicted and ultimately was. And the daughter, even  
21 though it's throughout the record the daughter supports her  
22 mother living independently, she manages her own finances and  
23 does very well on her own, and the daughter supports that. But  
24 in this case the daughter was -- knew that her mother's  
25 symptoms were exacerbating and was fearful that she would be

1 homeless.

2 Q Based on your review, was the daughter aware of other  
3 alternatives?

4 A No.

5 Q Did person 90 go immediately to the State Hospital after  
6 her daughter initiated commitment?

7 A She did not.

8 Q Where did she go?

9 A She went to a community hospital.

10 Q How long was she in the community hospital?

11 A I believe approximately three weeks.

12 Q If you will turn to tab 1108 in your binder, the document  
13 marked PX-1108.

14 A Yes.

15 Q Do you recognize this document?

16 A I do.

17 Q What is it?

18 A It is a psychiatric evaluation, and it's with the address  
19 at the top, Merit Health Batesville, and it pertains to  
20 person 90 admission there on 9-19-2016.

21 Q And was this written at the time of discharge of person 90  
22 from the community hospital?

23 A Yes.

24 Q Did you rely on this record in reaching findings about  
25 person 90?

1       A    I took it into consideration among the other records that  
2        were provided for me.

3                MS. VAN EREM: Your Honor, I move PX-1108 into  
4        evidence.

5                THE COURT: Any objection from the State?

6                MR. SHELSON: No, Your Honor.

7                THE COURT: PX-1108 will be received in evidence.

8                (EXHIBIT PX-1108 MARKED)

9        BY MS. VAN EREM:

10      Q    I will direct you to the paragraph on page 3 where it says  
11        "Discharge Criteria." What does that say?

12      A    It says, "Discharge Criteria: No SI, no HI," which is  
13        suicidal ideation, homicidal ideation. "No psychosis. No  
14        mania, depression, anxiety, irritability, anger, less than 3  
15        out of 10, --

16                THE COURT REPORTER: I'm sorry.

17                THE WITNESS: I'm sorry.

18      A    "No mania, no depression, anxiety, irritability, anger,  
19        less than 3 out of 10, if 10 is the worst." Period. "No side  
20        effects to medication and fully alert and oriented. However,  
21        this is" or "will likely not apply to her as I strongly believe  
22        she will be committed to the State Hospital and leave here to  
23        go on to the State Hospital."

24        BY MS. VAN EREM:

25      Q    What did you conclude after reading this record?

1       A    What I concluded is the physician who was her attending in  
2       the hospital had taken care of her for three weeks.  She was  
3       very stable.  This physician writes that there was no evidence  
4       of symptomatology of serious mental illness present, no  
5       lethality, no danger to herself or others, she was oriented,  
6       and that this physician had stabilized her.  But this last  
7       sentence implies that it doesn't matter, she is going to the  
8       State Hospital anyway.

9       Q    Generally, if someone is stabilized, do they need treatment  
10      in the State Hospital?

11      A    No.

12      Q    Why not?

13      A    Because they have stabilized, they are no longer in need of  
14      acute care, meaning for acute care you would need to be unable  
15      to care for yourself or a danger to yourself or others, and  
16      this is not apparent in this paragraph at all.

17      Q    In addition to concluding that person 90's most recent  
18      State Hospital admission could have been avoided, did you make  
19      any determinations regarding her length of stay in the State  
20      Hospital?

21      A    I did.

22      Q    What was that determination?

23      A    It appeared that she stayed too long.

24      Q    How long was her most recent stay?

25      A    I want to go back to her report.

1 Q Sure. It should be around page 22.

2 A Her most recent stay, I believe, was approximately 13 weeks  
3 in total. She came in in October, and she didn't leave until  
4 January. October of 2016 and then January 2017.

5 Q What was your conclusion that person 90 stayed too long in  
6 the State Hospital based on?

7 A Well, the indication of the community hospital said she  
8 went and she was stable and did not have any exacerbation of  
9 symptoms then. There was also a report in the record two days  
10 later from Mississippi State Hospital that determined that she  
11 did not meet criteria for admission on 10-13.

12 Also in the record, it indicated as early as the end of  
13 November that she appeared to stabilize and was at that time  
14 offered the option of a group home. But she didn't go until  
15 the third week in January 2017. So it seemed like a long time,  
16 to me, to stay in the State Hospital.

17 Q In your opinion, could she have been discharged sooner?

18 A Yes.

19 Q Once she was admitted to the State Hospital, what should  
20 have been taking place while she was there?

21 A At the very first, to begin the discharge planning on the  
22 day of admission. And the concern for this woman is that she  
23 was living in her own apartment and she had become evicted from  
24 that apartment. So a similar situation would need to be  
25 procured for her so that she could go back to that level of

1       independence in the community. So to start working on that  
2       right away in conjunction with person 90 and person 90's  
3       daughter.

4       Q     Did any of that occur?

5       A     It wasn't apparent, not to my knowledge. There was no  
6       indication that an apartment was being looked for for person  
7       90. She was offered a personal care home.

8       Q     How had person 90's circumstances changed from the time  
9       that she stopped going to medication appointments to the time  
10      that she was discharged from the State Hospital?

11      A     Her circumstances changed in that she had been living in  
12      her own apartment, she had been living at a high level of  
13      independence, she was managing her own finances, she was out  
14      and about in her community, and then she was committed and  
15      stayed in the hospital for the 13 weeks and then was discharged  
16      to a much more dependent setting, a personal care home. So she  
17      took a step down in her independence.

18      Q     Can you describe another example of a person who would have  
19      avoided or spent less time in a State Hospital?

20      A     I can talk about person 104.

21      Q     Okay. What are the circumstances of person 104 on page 125  
22      of your report?

23      A     Person 104 is a young woman. She is 38 years old. She is  
24      diagnosed with schizophrenia. She has had a trauma history, a  
25      lot of mental illness in her own family. She is working now

1       towards getting her GED. She is an artist. When I met with  
2       her, she showed me her pieces which are very, very interesting,  
3       very modern looking. And she has, I believe, been in the  
4       hospital four times.

5       Q     Did you interview another individual involved in person  
6       104's life?

7       A     I did. And that is the -- her informal caregiver who is  
8       the wife of the pastor of person 104's church, who has been, by  
9       person 104's report, tremendously supportive to her. She calls  
10      her her -- I think it's her godmother or her fairy godmother,  
11      that she just sees her as such an angel.

12      Q     Focusing on person 104's last admission, what led you to  
13      find that person 104 could have avoided or spent less time in  
14      the State Hospital?

15      A     She had also -- this was an individual who had an  
16      apartment. Her symptoms were starting to exacerbate which in  
17      her case is characterized by fighting, agitation. She was  
18      destroying property and was not able to be in that apartment  
19      any longer. And so she was, in fact, committed to the State  
20      Hospital.

21      Q     Did person 104 stabilize quickly when she was committed to  
22      the State Hospital?

23      A     She did. She did. She stabilized very quickly, according  
24      to the records.

25      Q     What happened after she stabilized?

1       A    She stayed there.  She actually stabilized I believe within  
2 a week from her admission.  She was admitted on May 31st, 2017,  
3 and appeared to stabilize by June 6th.  The problem was trying  
4 to find housing for her, that that was what was indicated in  
5 the record because she couldn't go back to her apartment, she  
6 had destroyed it, according to the record, and that she had  
7 very difficult relationships with family so she couldn't go  
8 back with them.

9       Q    After she had stabilized, did she have any incidents in the  
10 State Hospital?

11      A    She did.  She had -- there was an incident of -- she had  
12 talked with me and it was also in the record about noise really  
13 bothers her to the extreme, which I'm associating with some  
14 kind of traumatic event in her past.  She does have a trauma  
15 history.  But the noise really bothers her.

16           She had a couple of events of one where she threw a binder  
17 and another where she had destroyed some fixtures in a  
18 bathroom.

19      Q    And do you believe person 104 could have been discharged  
20 sooner than she was?

21      A    Absolutely.  I think the window was missed; that she had  
22 stabilized quickly, she was not discharged, and then the  
23 environment of the State Hospital and the noise triggered her,  
24 for whatever reason, and she had some problems.

25      Q    You mentioned some past aggressive behavior of person 104.

1 Is that right?

2 A Yes.

3 Q In your experience, can individuals with a history of  
4 aggressive behavior be safely served in the community?

5 A Absolutely. And once stabilized and services are provided  
6 to them, be it by a PACT team, case manager, connection with  
7 CMHC, then yes, they can live at a very high level of  
8 independence. And this woman has evidence. She told me on the  
9 interview that she now is living in a five-room house and  
10 living independently there. The house was obtained for her by  
11 her church.

12 Q Did you make a determination that person 104 is at serious  
13 risk of hospitalization?

14 A Yes.

15 Q You determined that she was?

16 A Yes, I did.

17 Q What services could help person 104 live safely in the  
18 community?

19 A She is an individual who is appropriate for a PACT team.  
20 The services that are within that PACT team I believe are very  
21 appropriate for her, specifically case management, which would  
22 offer, augment what the church is doing for her now, to give  
23 support to her informal support network so they are not the  
24 only ones. Also, the 24-hour crisis so that before symptoms  
25 exacerbate, to be able to contact, have local outreach --

1 THE COURT REPORTER: I'm sorry.

2 A To have access to 24-hour crisis service, to have mobile  
3 outreach so that she could have contact before her symptoms  
4 would exacerbate and would require her to be in a hospital.  
5 Also, support around her medication, her psychotropic  
6 medication connection there, support around her goals, which  
7 she has goals. She wants to get her high school diploma. She  
8 wants to pursue her art.

9 | BY MS. VAN EREM:

10 Q Had person 104 received these services?

11 A No.

12 Q Had she received any community-based services?

13 A She -- I also, as part of the collateral, interviewed the  
14 community mental health center staff who were working with her.  
15 In the record it shows that she comes in for a medication  
16 appointment, though in my opinion the appointments are too far  
17 apart. She also sees a nurse. And then there is a case  
18 manager that visits her. But when I spoke with the case  
19 manager, she really wasn't too familiar with -- because I  
20 thought the five-room house was so wonderful, but the case  
21 manager really wasn't too aware of that.

22 And the visits by the case manager did not seem to be in  
23 keeping with any kind of exacerbation of symptoms. There  
24 wasn't any indication that she stepped up the visits or did  
25 anything more during that period of time when person 104 was

1 starting to have problems in the community.

2 Q Could more intensive services have prevented person 104's  
3 hospitalization?

4 A I believe so, yes.

5 Q Dr. Baldwin, you testified earlier that the lack of  
6 community-based services has led to individuals being admitted  
7 unnecessarily or staying longer than necessary in State  
8 Hospitals. I would like to draw your attention to crisis  
9 services specifically. What is the goal of crisis services?

10 A The goal of crisis service is three-fold. It is to divert  
11 from hospital whenever possible, to stabilize the individual,  
12 and to then connect them to the next level of care, the most  
13 appropriate level of care for them.

14 Q You mentioned earlier that you developed crisis services in  
15 your work in Massachusetts. Is that right?

16 A I did.

17 Q Can you just briefly describe the crisis services that you  
18 developed?

19 A Yes. It's a continuum. It should begin with a proactive  
20 advanced crisis plan which is developed in conjunction with the  
21 individual, any supportive family members or friends, to talk  
22 with that individual when they're stable about what they would  
23 like to have happen to them if they start to get into a problem  
24 area with their medications. So first that.

25 But then at the lowest level, a "warm" line where someone

1 can call and chat for a variety of reasons, then a hot line  
2 where a person would call to get connected to a crisis service  
3 or be triaged for crisis, and then to have the mobile outreach  
4 capacity where clinicians are actually available to go out to  
5 where that individual is, be it their home or some other place.  
6 It could even be under a bridge or in a group home or whatever.  
7 Also, the capacity for people to come into an office to be able  
8 to meet with someone there if that would be preferable for them  
9 to do that.

10 And then to also have a crisis stabilization unit which is  
11 a short-term diversionary unit which can see people, have them  
12 be stable, talk with people, get reconnected with their  
13 medication, get connected with an appointment, whatever they  
14 need, and then to be discharged back home from the CSU.

15 Q When were the crisis services that you testified about  
16 developed in Massachusetts?

17 A They were.

18 Q When were they developed?

19 A Oh, when? We started right at the beginning in 1978 with  
20 the prescreening and then added services as we went along.  
21 Obviously, the prescreening emergency services center was open  
22 right then so people could come in, but we also had go-out  
23 capacity.

24 And then we -- the warm line and the hot line also right  
25 then in 1978. And then DCSU was later after we had established

1 the first part.

2 Q And I'm not sure you mentioned the term "prescreening"  
3 before. Can you describe what prescreening is?

4 A Prescreening, that's what we called it. I don't know -- I  
5 mean, it can go by a lot of different names but it is a mobile  
6 outreach capacity where a family member, anyone who is involved  
7 with a patient -- it could be law enforcement, it could be a  
8 homeless shelter -- sees a person with serious mental illnesses  
9 having trouble, and so they can call and speak immediately to a  
10 clinician. This is a live clinician that picks up the phone.  
11 It is not an answering machine. It's 24 hours a day. You  
12 speak with that person. A determination is made. And then, if  
13 need be, the prescreener or the clinician will travel to where  
14 that individual is.

15 Q Why were crisis services developed in Massachusetts?

16 A It's a hallmark of community-based -- comprehensive  
17 community-based services that support individuals with serious  
18 mental illness in the community. You have to have that. By  
19 nature of the illness that it is a chronic illness, and people  
20 do -- they get challenged by their symptoms periodically and  
21 they need help.

22 And oftentimes, as I said, it could be a warm line where  
23 they just call and chat. But maybe they need more. And then  
24 you want to be available to them to divert them from the  
25 hospital, stabilize them, and connect them back.

1           Excuse me. And it's good for family members, too, to be  
2 able to access those services.

3   Q    What happens if a mobile crisis team is called in and an  
4 individual is in a potentially dangerous psychiatric situation?

5   A    Well, the first thing that you do -- and I can speak from  
6 personal experience -- is that when you get a call, the first  
7 thing you do is get the contact information, where they are and  
8 how you can reach them or how you can dispatch help to them,  
9 because you may get disconnected, they may hang up, you may  
10 lose service.

11           The next is to assess danger and immediacy of the problem.  
12 And if you sense that there is a dangerous situation, you are  
13 going to take the steps that you need to protect that person  
14 and keep them safe.

15           For example, if it's a domestic violence situation, you may  
16 send police. If there is a potential for someone harming  
17 themselves, you are going to send your prescreener, maybe  
18 police, maybe an ambulance. You are going to send who needs to  
19 go there to help that individual. But always with the  
20 prescreener or the clinician.

21   Q    Turning back to your review in Mississippi, did you make  
22 any conclusions regarding crisis services based on the people  
23 you reviewed?

24   A    I did.

25   Q    What were your conclusions?

1       A    It seemed that it was lacking.  It seemed that there  
2       were -- in reports I read, that there were crisis teams, but  
3       when I spoke with individuals in my sample, it wasn't -- the  
4       only way I can describe it is it wasn't part of the culture  
5       where it wasn't automatically when you talk with someone, "Now,  
6       you know you have the crisis number, you can get a live  
7       clinician there any time.  Take this card and put it on your  
8       refrigerator.  Here it is.  This is a magnet, stick it in your  
9       car."  It wasn't that kind of a go-to information, because I  
10      did ask individuals and their family members, "Were you told  
11      about crisis?  Did you use crisis?  Were you aware of a crisis  
12      number?"  And it seemed to be lacking.

13      Q    For the people you reviewed, could mobile crisis services  
14      have prevented admission to a State Hospital?

15      A    For a number of them, yes, I believe so.

16      Q    How did you reach that conclusion?

17      A    It was looking at the pattern of symptoms and how they  
18      increased over time and that you could see in the record how it  
19      was just getting worse and worse and worse.  The individual was  
20      not accessing crisis.  The family members were not accessing  
21      crisis.

22           I would ask when -- there was one individual I asked, "Did  
23      you call the crisis line?"  "No."  You know, it just -- as I  
24      said, it didn't seem to be a culture or a go-to, that this was  
25      a hallmark of what you do, "We're here for you.  We're going

1 to -- you know, you just call us and we will help you."

2 Q And is what you described different than your experience in  
3 Massachusetts?

4 A Absolutely.

5 Q In what way?

6 A I mean, I can remember people calling the mental health  
7 center and they would say, "I think I'm going to be in trouble  
8 tonight." I mean, it would be during working hours and we  
9 would say, "Well, come in right now or, you know, we'll send  
10 your case manager out." "Well, I think I'm going to" --

11 THE COURT REPORTER: I'm sorry?

12 A People would call and say, "I think I'm going to be in  
13 trouble after you close." And we would say, "Call the crisis  
14 line. If you get in trouble, we're there." "Okay. Okay.  
15 Good. Thanks. Bye." I mean, it was a given that they knew  
16 about the crisis line and it was used, and it works.

17 BY MS. VAN EREM:

18 Q Can you give an example of a person that you reviewed in  
19 Mississippi where a mobile crisis may have prevented a State  
20 Hospital admission?

21 A I can. I would like to talk about person 117.

22 Q Okay. Can you briefly describe person 117's circumstances?  
23 Page 203 of your report.

24 A This is a young man. He is 33 or was 33 at the time of the  
25 interview. He is a father of young children. When we saw him,

1 he was living at his mother and father's home but he is someone  
2 who is working full-time. We didn't go to see him until the  
3 evening. He asked, because he is working during the day.

4 He is diagnosed with major depression and polysubstance use  
5 disorder.

6 Q How many state hospitalizations did person 117 have?

7 A He had one.

8 Q How could mobile crisis services have prevented his  
9 admission to a State Hospital, briefly?

10 A He is somebody that -- this individual before the State  
11 Hospital admission had had a very serious suicide attempt, and  
12 then just before this admission he had had a second suicide  
13 attempt. The commitment was initiated by family, his sister.  
14 And it was because he was becoming agitated, he was using  
15 drugs, he has access to weapons, and the family was just so  
16 fearful for him that they initiated a commitment.

17 Q So when was person 117's first hospitalization due to  
18 symptoms of mental illness?

19 A That was in the summer of 2015, and that was to a community  
20 hospital.

21 Q And was that in conjunction with his first suicide attempt?

22 A Yes. He took an overdose and he was on life supports.

23 Q Was he admitted to a State Hospital at that time?

24 A No.

25 Q What were the reasons for this -- sorry. Just one second.

1       What happened when he was discharged from the 2015  
2       hospitalization?

3       A    What happened when he was discharged?

4       Q    In 2015. Yes.

5       A    He was told that if he got in trouble again to call 911 or  
6       to go to the ER or to come back. He had been in the medical  
7       hospital first and then spent a couple of days at the -- at a  
8       community psych unit. And when he left there, he was told if  
9       you get in trouble again to call 911, go to the ED or come back  
10      to that hospital.

11      Q    Did you find any indications that person 117 had received  
12      community-based crisis services after this 2015  
13      hospitalization?

14      A    No.

15      Q    And when was person 117 hospitalized in the State Hospital?

16      A    That was in the summer of 2017.

17      Q    What had occurred immediately before that 2017 State  
18      Hospital admission?

19      A    His symptoms of depression had increased. He was agitated.  
20      He was continuing to use drugs. He had -- about a week before  
21      that, had a -- all suicide attempts are serious, but this one  
22      was not as serious as the one in the summer of 2015. But he  
23      had taken an overdose again and the family was very frightened  
24      for him and so they initiated commitment.

25      Q    Where did person 117 go after his family filed commitment

1 paperwork?

2 A He went to jail.

3 Q How long was he in jail?

4 A It was approximately a week, I would say the better part of  
5 a week.

6 Q Had he been charged with any crime?

7 A No.

8 Q Turn to tab 1109 in your binder, the document marked  
9 PX-1109. Is this a document you reviewed?

10 A Yes.

11 Q What is it?

12 A It is the South Mississippi State Hospital discharge  
13 summary, and it's -- the admit date is 8-16-2017. Date of  
14 discharge, 9-8-2017.

15 Q Did you rely on this record in reaching your conclusions  
16 about person 117?

17 A I did. I took it into consideration.

18 MS. VAN EREM: I move to admit PX-1109 into evidence.

19 THE COURT: Any objection from the State?

20 MR. SHELSON: No, sir.

21 THE COURT: All right. PX-1109 will be received into  
22 evidence.

23 (EXHIBIT PX-1109 MARKED)

24 BY MS. VAN EREM:

25 Q So turn to page 5 of this record. Will you please read the

1       paragraph that says, starts with "Follow-up Care"?

2       A    "Follow-up Care: The patient is to follow up at Pine Belt  
3       Mental Health in Mississippi, at 8:00 a.m. on 9-12-2017. The  
4       patient is to follow up with his primary care doctor for any  
5       medical issues as needed."

6       Q    And will you also please read the last paragraph in this  
7       document?

8       A    "Instructions to Patient and Family: The patient and the  
9       patient's family were educated on the patient's medication  
10      regimen and the date and time of his follow-up appointments.  
11      They were instructed in the importance of the patient taking  
12      his medication as prescribed and keeping his outpatient  
13      appointments. The patient and the patient's family verbalized  
14      understanding of discharge instructions."

15      Q    Was this record relevant to your findings?

16      A    It was.

17      Q    In what way?

18      A    I'm finding the follow-up care and the instructions to the  
19      patient and family as lacking, and there is really nothing in  
20      here about crisis services. But I am also concerned that the  
21      burden, the complete burden of affecting follow-up care is  
22      placed on the patient and his family. Not only the psychiatric  
23      part but the medical part as well. And this is a man who has  
24      chronic pain, which was the beginning of his drug use to begin  
25      with, was that he takes opiates for his pain or medication to

1       dull the pain.

2           And so even to place the burden both psychiatrically and  
3       medically on him, it seems like healthcare providers have an  
4       obligation to do more to help people connect.

5   Q   Did you make any findings about whether person 117 is at  
6       serious risk of hospitalization?

7   A   I did.

8   Q   What were your findings?

9   A   He is. He is at risk.

10   Q   In your experience, have people with similar severity of  
11       serious mental illness as person 117 been safely served in the  
12       community without being at serious risk of hospitalization?

13   A   Absolutely. Did you want me to elaborate?

14   Q   Sure.

15   A   I mean, this is an individual -- and I have known  
16       individuals in my experience very similar to this young man.  
17       He has, as he verbalized, a lot to live for. He has young  
18       children. He wants to stay involved in their lives. He has  
19       hobbies, he has a job, he has goals, and he is someone who is  
20       very interested in getting well, which he talked about the  
21       plans that he has for that.

22           However, he has challenges. He has chronic pain. He has a  
23       history of drug use and he also has a history of depression.

24   Q   What services would person 117 need to be safely served in  
25       the community?

1       A    The crisis services first and foremost.  And that would be  
2       24-hour a day availability of a clinician.  The range that I  
3       discussed previously, both available to the individual, also to  
4       his family members.  I spoke at the time of the interview with  
5       his mother, and she was very concerned about how they can help  
6       their son.

7               The other thing that's important for him is to connect him  
8       with recovery services.  He has a substance use disorder.  To  
9       be connected with a 12-step program and a sponsor.  And he is a  
10      veteran.  And so it would be appropriate for him to be  
11      connected with veteran services.  So through that, to have a  
12      case management function, either through a sponsor or through  
13      the veteran service, would be appropriate for him.

14              Also, he would need connection with a psychiatric  
15      prescriber.  He is somebody who at this point wants to wean  
16      himself off medication but at least to have that relationship  
17      if need be, and connection, as I said before, to the medical  
18      because of his chronic pain.

19       Q    Did person 117 receive those services in the community?

20       A    He did not.  The other piece is benefits assistance for  
21      him.  I would add that.

22       Q    And we will go into this a little bit more later but what  
23      is benefits assistance?

24       A    To help people obtain the -- the ability to pay for their  
25      healthcare.  It can be -- for this individual, it might be

1       through the Veterans Administration, but also for people to  
2       obtain healthcare insurance or to get on a disability insurance  
3       or whatever is appropriate for them to help them pay for not  
4       only their psychiatric treatment, community-based services, but  
5       their medication.

6       Q     Did person 117 receive any community-based mental health  
7       services?

8       A     He had been referred for outpatient groups and to meet with  
9       a nurse and to receive medication in the community, and he --  
10      he went for a while but he stopped for a variety of reasons  
11      that he talked with me about.

12      Q     What were some of those reasons?

13      A     He does not have transportation so it was hard to get  
14      there. He worked, so he would need appointments that were in  
15      the evening or on the weekend. He also was very concerned that  
16      he had to pay for the visits. He said the visits are \$25 a day  
17      and he is having trouble affording that, which is also  
18      something his mother talked about.

19           And that to be -- I didn't -- in my opinion, the services  
20      he was referred to were not the best services for him. He  
21      doesn't want to take medication. So to refer him for a  
22      medication and tell him yes, to take it, or to be in groups may  
23      not be appropriate for him. There was nothing with regard to  
24      his substance use disorder either.

25      Q     What happened when he stopped going to outpatient

1 treatment?

2 A The first time or the second time?

3 Q You mentioned that he had been going to some outpatient  
4 appointments but stopped going.

5 A I would have to say that he just has been kind of on his  
6 own since then. He is weaning himself off medication.

7 Q And did the community mental health center reach out to him  
8 when he stopped going to his appointments?

9 A I asked about that, and he said, "If I miss an appointment,  
10 they will send a letter or they will call." But it's not  
11 their -- they have left messages or they send the letter. It  
12 is not that they've talked with -- he said he hadn't talked  
13 with them directly.

14 Q Based on your experience, would you expect a different  
15 approach, given person 117's history?

16 A I would. I would expect a more hands-on approach with  
17 someone like this individual. He has had two suicide attempts  
18 within the past three years, and he has major depression, he is  
19 a substance use disorder person. He is -- he has some high  
20 lethality risk. I would want to stay very much on top of him.  
21 I would want a case management function to be very much aware  
22 of how he is doing all the time.

23 Q What do you mean by high lethality risk?

24 A That he is someone who could enter into that same situation  
25 that he was in in summer of 2015 or in 2017 where he becomes

1       depressed, he starts using drugs, and he takes another  
2       overdose.

3       Q     What effect could crisis services have had on person 117?

4       A     The 24-hour capacity is important because that would be  
5       accessible both to his family. If the individual didn't call,  
6       then the family could call. But just to say, "We're worried  
7       about our son." Or his girlfriend could say, "I'm worried  
8       about the father of my children. I want someone to see him. I  
9       think he is using again, I'm not sure." You know, and to get  
10      in front of the symptoms and to get connection right away in  
11      this case to keep him safe but also to avoid any further  
12      hospitalization. It's the appropriate care for this individual  
13      with these symptoms.

14      Q     You mentioned benefits assistance and I would like to go  
15      back to that a little bit. In your professional experience,  
16      should benefits assistance be provided to people with serious  
17      mental illness?

18      A     Absolutely.

19      Q     Why?

20      A     Well, in the case of this individual, and there were  
21      several other, where they did not have -- oftentimes when  
22      people have serious mental illness, they have trouble  
23      organizing their thoughts or planning what they need to do in  
24      an organized way. So to apply for healthcare benefits on their  
25      own can be challenging. And so to have someone help with those

1 applications or those interviews or providing the documents,  
2 the proof needed, to have coverage for your medication. I had  
3 one individual who was not able to obtain his medication  
4 because -- his shot, his intramuscular shot, because he didn't  
5 have his insurance in place.

6 Q Who should provide benefits assistance?

7 A It can be provided by a number of individuals. But,  
8 appropriately, the case manager can help.

9 Q Does the hospital have a responsibility to provide benefits  
10 assistance?

11 A Absolutely. The social worker in the hospital is an ideal  
12 person for that role.

13 Q How could benefits assistance have affected person 117's  
14 risk of hospitalization?

15 A If he had benefits in place, and it is something that he  
16 says he wants to have, that he is working but he is not sure  
17 how he could even get it through his work, he has heard stories  
18 from coworkers about how to get it, but in this case he  
19 wouldn't have to pay for his visits, which he said was a  
20 deterrent to him going to the visits, it's \$25 out of pocket.  
21 So it might have helped him get more connected with the mental  
22 health center if he had insurance to support that.

23 And then I would see the mental health center, once the  
24 connection is made, helping him with those other services that  
25 I discussed previously.

1 Q Did you find that benefits assistance may have prevented  
2 unnecessary hospitalization for other individuals in your  
3 review?

4 A I did.

5 Q Going back to crisis services, did the lack of access to  
6 crisis services lead to unnecessary hospitalization for any  
7 other individuals you reviewed?

8 A Yes.

9 Q Can you provide another example?

10 A I can. I would like to talk about person 108.

11 Q Can you tell us a little bit about person 108? It is on  
12 page 150 of your report.

13 A This is a very young man. At the time of the interview, he  
14 was 27 years old. He had been in -- had eight State Hospital  
15 admissions in the past nine years.

16 When I saw him -- I'm just going to get on my page here --  
17 he was living with his grandmother, and the grandmother was  
18 very knowledgeable about his illness and very in touch with  
19 what his symptoms are.

20 He has, I would say, an underlying symptomatology at all  
21 times that he is struggling with. And with the support of his  
22 grandmother, he is managing. He was -- I will just say briefly  
23 he is delightful. He is very interested in sports and he could  
24 talk about basketball and baseball forever. You know, it was a  
25 very animated discussion.

1 Q You mentioned the term "underlying symptomatology." Do you  
2 mean that he experiences symptoms most of the time?

3 A Yes. Yes.

4 Q What typically triggers person 108's hospitalization?

5 A His description and the grandmother's description is he  
6 becomes -- particularly in the wintertime when it's dark, he  
7 becomes isolated, he is not able to go out as much. He is  
8 always struggling with these symptoms. He has a fixed  
9 delusional system about there has been a lot of losses in the  
10 family and he somehow in his delusion believes that he could  
11 prevent these if he could learn more about who or what is  
12 making them happen. So he becomes isolated and the symptoms  
13 increase. He goes in his bedroom, he tries to drown out the  
14 voices and the thoughts, and he can't.

15 Q Why did you find that crisis services could have prevented  
16 unnecessary hospitalization in person 108's case?

17 A Because he has a lot of strengths. He is someone who is  
18 very -- he has a good deal of insight into his symptoms. And  
19 his grandmother -- he lives with his grandmother who is a  
20 tremendous support. And the 24-hour crisis services would  
21 offer a contact for them when these symptoms start increasing.  
22 And the grandmother could call and say, "I would like someone  
23 to come visit my grandson and talk with him and figure out  
24 what's going on." He might call and talk with the hot line or  
25 he might talk with a clinician.

1           And if symptoms were continuing, he might even -- it would  
2 be appropriate for him to have a stay at crisis stabilization,  
3 get connected on maybe a higher dose of medication temporarily,  
4 have someone to talk to, feel in a safe place.

5   Q   Did person 108 receive those crisis services?

6   A   No. It was not indicated in the record.

7   Q   Could crisis services have prevented his last admission to  
8 the State Hospital?

9   A   I believe so. And the others as well. He has had a number  
10 of them at such a young age.

11   Q   In your professional experience, have you seen people like  
12 person 108 able to be served in the community without repeated  
13 hospitalizations?

14   A   I have. I have.

15           MS. VAN EREM: Your Honor, I'm getting close to the  
16 end but I maybe have I would estimate about 20 to 30 minutes  
17 left. I'm not sure if you would like to take a lunch break now  
18 and then I can wrap up after lunch or if I should keep going.

19           THE COURT: You should keep going. I mean, we will do  
20 our cross-examination after lunch.

21           MS. VAN EREM: Okay.

22   BY MS. VAN EREM:

23   Q   Dr. Baldwin, did you make any findings regarding state  
24 hospital discharge practices?

25   A   I did.

1 Q What were your findings?

2 A I have kind of mentioned it before but I can say I did not  
3 see the discharge planning taking place right at the point of  
4 admission, which is standard practice. I did not see the  
5 inclusion of the individual or their informal support network  
6 involved in discharge planning as much as -- as I thought it  
7 should be, given my experience.

8 And, also, I didn't see the transition kinds of activity  
9 between the hospital and the community mental health center  
10 that is proven to be successful. And I can describe that  
11 activity if you want or --

12 Q Sure. If you can briefly describe the transition activity.

13 A To have the community mental health center involved right  
14 from the beginning, that staff or the case manager or other  
15 staff that would be working with that patient, come to the  
16 hospital, meet with the patient, meet with hospital staff,  
17 participate in meetings, and so that the individual has a  
18 familiar face that when they go out, they know they have  
19 already made a connection with that person. And to start right  
20 at the beginning, shared records. There is all kinds of ways  
21 that a transition phase can take place.

22 The other thing that I saw is oftentimes with individuals,  
23 they would be in the hospital for a while, they would be  
24 stabilized, and at that point the discharge planning would take  
25 place. So it would mean that a person is -- has very few

1 symptoms and yet they're still in the hospital waiting to be  
2 discharged.

3 Q And to be clear, that's what you saw in Mississippi in your  
4 review?

5 A I did.

6 Q What was the effect of this inadequate discharge planning?

7 A People ended up staying in the hospital longer. The  
8 connections were not made with the community-based services as  
9 would effect a successful discharge. And so the person would  
10 come out of the hospital and they may or may not connect with  
11 the community-based services because it's difficult at that  
12 point.

13 Q And then what would happen if there was --

14 A Then they would go back into their pattern of an  
15 exacerbation of symptoms, no one to connect with, and then end  
16 up needing a higher level of care.

17 Q And by higher level of care, are you referring to  
18 hospitalization?

19 A A hospitalization, yes.

20 Q Are there any examples of people you reviewed who did not  
21 receive an adequate discharge planning process?

22 A There are. I can talk --

23 Q Will you share one example?

24 A I can talk about person 92.

25 Q If you will please briefly describe person 92. It's on

1 page 35 of your report.

2 A This is a young woman. She is 30 years old. I'm just  
3 going to get to my page. She has had six hospitalizations to  
4 the State Hospital, according to the record. She is someone  
5 who is diagnosed with substance use disorder but also  
6 schizophrenia. She is someone who has lived independently on  
7 her own. At this point she is in a program out of state.

8 Q What is your basis for saying that person 92 did not  
9 receive an adequate discharge planning process?

10 A Well, I reviewed her hospitalizations. I also spoke with  
11 her and I spoke with her mother as well. And with the six  
12 hospitalizations -- and again, she is 30 years old, so, you  
13 know, they have all taken place recently from a young adult to  
14 present. The first two, there was no indication of any  
15 discharge planning. There was no aftercare plan for her,  
16 according to the records from the State Hospital.

17 The third one, she was discharged to her grandfather, and  
18 the grandfather was tasked with connecting her with another  
19 family member out of state. So no discharge planning there.

20 The fourth one, it was all aftercare service, were simply  
21 referred to the -- what is it called, the CR -- the  
22 residential, central residential program. So the program was  
23 tasked with all the aftercare services, so there was nothing  
24 specific there.

25 The fifth one, she was discharged to a man, an older man

1 who had lied twice about his relationship with her, and  
2 ultimately it was found, per the mother's report in the record,  
3 that he is in prison and he had been exploiting her,  
4 prostituting her, giving her drugs. So that was the fifth  
5 admission.

6 The sixth, she was discharged, and that was at that point  
7 when she went to Ohio to live, and her mother was tasked with  
8 getting her into a program in Ohio, which is where she is now.  
9 So there was no planning for that one either, just discharged  
10 to the mother.

11 Q How did person 92's discharge planning process differ from  
12 professional standards?

13 A In my opinion, the best discharge planning is, again,  
14 taking place from the point of admission. It's involving the  
15 individual and the family member but also making those  
16 connections for that individual, and the individual meeting  
17 people who are going to be treating him or her in the community  
18 and not tasking family members with the full burden of the  
19 discharge -- the aftercare planning and the connection with  
20 community services.

21 Q How did person 92's discharge experience affect her?

22 A She cycled back into the hospital six times because there  
23 was no connection. This last time she had been three weeks  
24 living in woods behind Walmart. She had been homeless. The  
25 time before that, as I said, she had been exploited and had

1       been prostituted.

2           So the connections within the community for her substance  
3       use disorder and also her serious mental illness were not being  
4       treated at all.

5   Q    Dr. Baldwin, do you have any other examples about  
6       individuals who have experienced unnecessary hospitalization  
7       that you would like to share with the court today?

8   A    I can talk about person 91.

9   Q    If you can tell us a little bit about person 91. It starts  
10      on page 27 of your report.

11   A    Person 91 is a 59-year-old African-American man. On the  
12      day that I saw him, he came to meet us in a meeting room at  
13      Jaquith Nursing Home. I'm sorry. I want to find the beginning  
14      here.

15   Q    Sure.

16   A    He has had a total of 17 admissions to State Hospital. And  
17      he is a double amputee. He came to us in a wheelchair that was  
18      being pushed by someone else, but he had shared with us that  
19      his own wheelchair, where he is able to mobilize, had been  
20      taken away from him, he didn't have that.

21           He was, again, a very animated person, very upbeat, very  
22      wanting to talk with us about his strong desire to leave the  
23      nursing home. And we talked a lot about his hobbies and his  
24      interests and his desires.

25   Q    You mentioned the nursing facility. Is Jaquith Nursing

1 Facility associated with the State Hospital?

2 A It is associated, I believe, and it is on the grounds of  
3 the State Hospital. I know when I see physical exams of the  
4 patients, it's on Jaquith stationery, so I think they do the  
5 physical examinations for patients.

6 Q You mentioned person 91 talked to you about his hobbies.

7 What does he like to do?

8 A He is a musician, and he has played in Chicago in all the  
9 blues places. He talked about other musicians. He loves to  
10 improv, improvise. He plays a saxophone. He plays a  
11 harmonica. He plays clarinet or he wants to learn clarinet.  
12 He is very interested in music. He has been his whole life.

13 Q Was he able to play the saxophone during his most recent  
14 admission to the State Hospital?

15 A He had asked for a saxophone and I had interviewed his  
16 friend who confirmed that he brought his saxophone to the  
17 hospital. But for some reasons, he was unable to play it  
18 without some adaptations, so the saxophone was locked up for  
19 safekeeping. That's what the record said. So he never was  
20 able to play it, unfortunately, although he wanted to.

21 Q What were the reasons for his most recent admission to the  
22 State Hospital?

23 A He had been living in a nursing home and he is very -- he  
24 is a strong personality, as I described, and his brother  
25 described him that way, as his friend did as well. And he

1 likes to smoke cigarettes. He likes to make his own decisions  
2 and be as independent as possible, and the nursing home was not  
3 allowing him to smoke his cigarettes. And so over time he got  
4 increasingly more agitated and more agitated and got engaged in  
5 some bizarre behavior around wanting to smoke, and ultimately  
6 the nursing home initiated the commitment process.

7 Q How long did this most recent admission last? I think it's  
8 on page 30.

9 A He came in in June of 2015, and he did not leave until  
10 March 2016. So he was there quite a long time.

11 Q Did you make any findings regarding whether person 91 could  
12 have avoided or spent less time in State Hospitals?

13 A Absolutely. This is someone who has cycled in and out of  
14 State Hospitals 17 times over his life, and that the aftercare  
15 services that could be available to him in the community were  
16 not being provided.

17 Q So to clarify, did you find that he could have avoided or  
18 spent less time in State Hospitals?

19 A Yes.

20 Q During his most recent admission, did person 91 want to be  
21 in a State Hospital?

22 A Oh, no. He was very adamant about wanting to leave. He  
23 talked with us at length about it. And, also, it was  
24 documented in the records frequently how he wanted to leave.  
25 He had shared that he agreed to a nursing home because he

1       thought it would be a stepping stone to the community and to  
2       his own apartment. He thought it would be easier to get out of  
3       the nursing home than to get out of the State Hospital.

4       Q    If you'll turn to tab 1110 in your binder, document marked  
5       PX-1110. Is this a document you reviewed? It's also on the  
6       screen.

7       A    Yes.

8       Q    What is this document?

9       A    This is a Mississippi State Hospital clinical progress  
10      note. It's a psychology weekly note and it's dated July 7th,  
11      2015.

12                    MS. VAN EREM: Your Honor, I move PX-1110 into  
13      evidence.

14                    THE COURT: Any objection from the State?

15                    MR. SHELSON: No, Your Honor.

16                    THE COURT: PX-1110 will be received into evidence.

17                    (EXHIBIT PX-1110 MARKED)

18       BY MS. VAN EREM:

19       Q    Can you read the highlighted portion of this record,  
20      Dr. Baldwin?

21       A    I can. "No significant behavioral problems noted during  
22      the review period. Person 91 was observed as being calm and  
23      cooperative in the milieu. He was generally seen rolling his  
24      wheelchair in the hallway or different areas of the building.  
25      Mood appears stable with no signs of aggression or anger

1 observed or reported. He continues to deny SI," suicidal  
2 ideation, "homicidal ideations. He continues to have limited  
3 insight and awareness into his condition, AEB" -- or as  
4 evidenced by -- "stating, *I don't know why they put me here.*  
5 *I'm just ready to leave here. This is like a prison.*"

6 Q Dr. Baldwin, what did you conclude from looking at this  
7 record?

8 A It's very similar to the way I saw him, the way he  
9 presented, that there was no evidence of exacerbation of  
10 serious mental illness symptoms. He was calm. He -- his mood  
11 appeared stable, no anger or aggression. Absence of symptoms.  
12 He has never expressed any suicidal or homicidal ideations.  
13 That's not part of his symptomatology.

14 And the part that was concerning to me is he continues to  
15 have limited insight and awareness into his condition by  
16 stating, "I don't know why I'm here, I'm ready to leave,"  
17 whereas I don't see that as limited insight. He is talking  
18 about what his goals are. He wants to leave and he wants to be  
19 more independent.

20 And the answer, if I just -- one more thing. The response  
21 to that is simply, "I will continue to monitor and assess  
22 patient progress." There is no intervention based on that,  
23 saying, "Well, let's talk more about what your goals are," or  
24 "You seem to not be having any symptoms right now. Let's take  
25 the next step." That's not there.

1 Q How much longer was he in the State Hospital after this  
2 progress note was written?

3 A Well, that was in July 2015, and so he did not leave  
4 until -- and I've got to find it again so I can tell you  
5 exactly.

6 Q I think it's on page 30.

7 A He didn't leave until March 2016. So that's several months  
8 prior.

9 Q If you will turn to tab 1111 in your binder, document  
10 marked PX-1111. Is this a document you reviewed?

11 A It is.

12 Q What is it?

13 A It's Mississippi State Hospital clinical progress note, and  
14 it is the Social Service weekly note, and it is dated  
15 August 7th, 2015. There is no treatment plan problem number  
16 there, so that's absent.

17 Q Can you please read the highlighted portion?

18 A "Person 91 met with SW," or social worker, "several times  
19 this week. He let social worker know that he has been praying  
20 to God and that he is helping to carry him through. Person 91  
21 asked social worker, or SW, each day about going home. SW  
22 explained to him that he is not quite ready for discharge but  
23 that if he continues to go to his groups and comply with his  
24 medication, when he is ready, social worker will refer him for  
25 placement."

1 MS. VAN EREM: Your Honor, I move PX-1111 into  
2 evidence.

3 THE COURT: Any objection from the State?

4 MR. SHELSON: No, sir.

5 THE COURT: PX-1111 will be received into evidence.

6 (EXHIBIT PX-1111 MARKED)

7 BY MS. VAN EREM:

8 Q Dr. Baldwin, did this record contribute to any of your  
9 conclusions?

10 A It did.

11 Q In what way?

12 A It supports the way he talked with me in the interview,  
13 also with other notes in the record, that he is continuously  
14 asking and, in this case, each day, about going home and that  
15 he is feeling -- I am interpreting from this that he is praying  
16 to God that he is helping him to get through this, trying to be  
17 patient.

18 But the other part that was concerning to me is the social  
19 worker is saying, "You are not ready for discharge, but if you  
20 behave or you go to your group," she doesn't -- that's my word,  
21 "behave," continue to go to your groups and comply with  
22 medication, when he is ready, social worker will refer him. He  
23 is saying he is ready now. And so that's not what the social  
24 worker is doing. And she is looking or he is looking for  
25 nursing home placement as the best option.

1 Q We have one more document. So if you'll please turn to  
2 tab 1112 in your binder, the document marked PX-1112. Is this  
3 a document you reviewed?

4 A Yes, it is.

5 Q What is this document?

6 A This is Mississippi State Hospital clinical progress note,  
7 and this is dated September 2nd, 2015. And it is a Social  
8 Service weekly note.

9 MS. VAN EREM: Your Honor, I move PX-1112 into  
10 evidence.

11 THE COURT: Any objection from the State?

12 MR. SHELSON: No, Your Honor.

13 THE COURT: PX-1112 will be received into evidence.

14 (EXHIBIT PX-1112 MARKED)

15 BY MS. VAN EREM:

16 Q Dr. Baldwin, can you please read the highlighted sentence?

17 A "He does not specify what is bothering him but he continues  
18 to say, *I got to get out of here* -- or "her," but that's a  
19 typo -- *got to get out of here; these people treat me like a*  
20 *child.*"

21 Q Okay. And can you read the next highlighted portion as  
22 well?

23 A "Person 91 initially asked SW or social worker for boots  
24 when he was admitted, but after a few weeks he stopped asking.  
25 This week person 91 asked social worker to get him a sixe" -- a

1 size, that's a typo -- "size 10 tennis shoe so that he can wear  
2 them on his stumps. Person 91 does not seem to realize that he  
3 can't walk on his stumps. When social worker told him that he  
4 couldn't have tennis shoes for his stumps, he noted, *I will get*  
5 *some when I get out.*

6 Social worker let him know that that was an indicator that  
7 he was not ready to leave and he started speaking in a whining  
8 voice as if he were crying and said, *Y'all ain't gone never let*  
9 *me out of here.* Social worker tried to explain to him that he  
10 would be discharged when he was ready, but he did not want to  
11 listen to reason."

12 Q Dr. Baldwin, did this record contribute to any of your  
13 conclusions?

14 A It did.

15 Q In what way?

16 A It is -- I am very much aware that people with -- are  
17 double amputees. There are some people who have long leg  
18 prosthesis. Other people prefer to walk on their stumps. They  
19 have special shoes that allow them to walk on their stumps.  
20 Some people have even had skin grafts to allow the skin to be  
21 tougher on the stumps. And this individual has a history of  
22 walking on his stumps, which he talked to us about. And yet  
23 here -- and it is also in other parts of the record as well,  
24 his wanting to get out, wanting to walk on the stumps is being  
25 viewed by staff as an indicator that he is not ready to leave,

1 when, in fact, he is asking to go and he is asking to have a  
2 way to be more independent so that he can ambulate.

3 Q In your experience, have you served individuals with  
4 similar levels of severity as person 91 in the community?

5 THE COURT REPORTER: I'm sorry?

6 BY MS. VAN EREM:

7 Q Have you served individuals with similar levels of severity  
8 of serious mental illness as person 91 in the community?

9 A I have.

10 MS. VAN EREM: Your Honor, if I may just have a brief  
11 moment to confer?

12 THE COURT: Yes, you may.

13 (SHORT PAUSE)

14 BY MS. VAN EREM:

15 Q A couple more questions. Dr. Baldwin, you previously  
16 testified that the burden of ensuring an individual stays  
17 connected to community-based services should be shared between  
18 the individual and mental health providers. Is that right?

19 A Correct.

20 Q Do individuals with serious mental illness have difficulty  
21 staying connected to treatment on their own?

22 THE COURT REPORTER: I'm sorry.

23 MS. VAN EREM: I'm sorry.

24 BY MS. VAN EREM:

25 Q Do individuals with serious mental illness have difficulty

1       staying connected to treatment on their own?

2       A    In general, yes. And I had testified earlier that there  
3       is -- it's challenging oftentimes to organize thoughts, to plan  
4       ahead, to think about having an appointment, writing an  
5       appointment, getting yourself there, navigating the waiting  
6       room or an auto attendant on a phone. Those are all challenges  
7       to stay connected.

8       Q    Why are those challenges specifically for people with  
9       serious mental illness?

10      A    Because they have -- in general, it is an executive  
11       functioning or it is a piece of the brain that often has  
12       trouble organizing. I mean, I think, you know, I can speak for  
13       myself, I have trouble organizing sometimes remembering  
14       appointments, and they do. It also is a trust issue, to be  
15       able to build a relationship with someone to connect with them  
16       so that you can receive your services and continue to do that.  
17       So people with serious mental illness have those challenges.  
18       They also may have paranoia or suspicion where it is hard for  
19       them to connect with anyone. They tend to be isolating  
20       themselves.

21      Q    And how can community providers help people stay engaged in  
22       community-based treatment?

23      A    The range of community-based services are -- each and every  
24       one is very important. Some may be more important for some  
25       individuals, a PACT team, a case manager, connection to a

1 psychiatric prescriber, 24-hour --

2 THE COURT REPORTER: I'm sorry.

3 THE WITNESS: That's okay. Where did I go too fast?

4 A A case manager, connection to a psychiatric prescriber,  
5 connection to primary care for their co-morbid medical, a  
6 connection to substance use treatment if that's needed. And  
7 all of these services to a greater or lesser degree are going  
8 to be very effective in supporting people in the community.

9 BY MS. VAN EREM:

10 Q Thinking back on your review, do you have any lasting  
11 impressions from your experience doing the review in  
12 Mississippi?

13 A I do. I have included in my assessments before this, this  
14 particular project, throughout my whole career, when I meet  
15 with people, I ask them about their three wishes. And so I was  
16 glad that it was included in this interview where we would ask  
17 people about their three wishes, because it gives them an  
18 ability to imagine, to step outside of their situation. And  
19 then it's the foundation of goals.

20 Q And when you say their three wishes, do you mean if you had  
21 three wishes, what would they be? That question?

22 A "If you had three wishes, what would they be?" And to just  
23 think about that. And people would, for the most part, give me  
24 those three wishes that they would -- they would think about it  
25 and then they would provide the three wishes. And the

1 foundation of recovery in serious mental illness is to have  
2 goals, to have your own goals. And so to develop goals, you  
3 can start with wishes. And then the wishes themselves were --  
4 their wishes were things like, "I would like to live in my own  
5 house," or "I would like to have enough money to do the things  
6 I want to do," or "I would like to be close with loved ones."  
7 And when you think about it, those are the wishes we all have.

8 MS. VAN EREM: I have no further questions at this  
9 time.

10 THE COURT: Okay. All right. It is appropriate for  
11 us to take our lunch break at this time. It's about 12:46.  
12 Let's start back up at 2:05.

13 And, Dr. Baldwin, you may step down and we'll begin  
14 your cross-examination at 2:05.

15 THE WITNESS: Okay.

16 THE COURT: All right. Thank you.

17 *(Lunch Recess)*

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1 CERTIFICATE OF REPORTER

2

3 I, BRENDA D. WOLVERTON, Official Court Reporter, United

4 States District Court, Southern District of Mississippi, do

5 hereby certify that the above and foregoing pages contain a

6 full, true and correct transcript of the proceedings had in the

7 aforesigned case at the time and place indicated, which

8 proceedings were recorded by me to the best of my skill and

9 ability.

10 I certify that the transcript fees and format comply

11 with those prescribed by the Court and Judicial Conference of

12 the United States.

13 This the 12th day of June, 2019.

14

15 s/ Brenda D. Wolverton  
U.S. DISTRICT COURT REPORTER

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